

2115
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 332

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY	Wicomico	STATE	Maryland
CITY (If outside corporate limits, write RURAL OR and give nearest town)	Wicomico	COUNTY	Wicomico
TOWN	Willards	CITY (If outside corporate limits write RURAL and give nearest town)	Wicomico
HOSPITAL OR INSTITUTION OR STREET ADDRESS	R.D. # 1 Willards	STREET ADDRESS	R.D. # 1 Willards
3. NAME OF DECEASED:	(First) JOHN	(Middle) CURTIS	(Last) BAKER
4. DATE OF DEATH	FEB.	19	th 19 55
5. SEX:	Male	6. COLOR OR RACE:	White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	Single	8. DATE OF BIRTH:	Sept. 10, 1876
9. AGE last birthday:	78	10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	Laborer on Farm
11. BIRTHPLACE (State or foreign country):	Near Bethol Delaware	12. CITIZEN OF WHAT COUNTRY:	USA
13. FATHER'S NAME:	Unk	14. MOTHER'S MAIDEN NAME:	Nancy Baker
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	Unk	16. SOCIAL SECURITY No.:	
17. INFORMANT & ADDRESS:	Mrs. Lillie Lewis		

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
Immediate cause (a) Coronary Occlusion		Sudden
Antecedent cause(s) (b) Arterio-sclerotic Heart Disease		
DISEASE OR CONDITION CAUSING DEATH.		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <i>Walter R. Holloway</i> CHIEF MEDICAL EXAMINER DATE SIGNED M. D. DEPUTY MEDICAL EXAMINER ASSISTANT MEDICAL EXAM. <input type="checkbox"/> Feb. 22 1955		
23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY
Burial	Feb. 22, 1955	Line Church Cemetery
LOCATION (City, town, or county) (State)	Near Whitesville, Delaware	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
2-22-55	Walter R. Holloway	HOLLOWAY & COMPANY SALISBURY MARYLAND

Walter R. Holloway

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 25 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02068
2080 CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>12 SALISBURY</u>		LENGTH OF STAY (in this place) <u>1 Day</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Snow Hill 23X-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>82 Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u></u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>ELLA E. BIRCH</u>			4. DATE (Month) (Day) (Year) OF DEATH: <u>February 27 1955</u>				
5. SEX: <u>7</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u></u>	8. DATE OF BIRTH: <u>Sept. 19-1874</u>		9. AGE last birthday <u>80/5/8</u> yrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Powellville, md</u>		12. CITIZEN OF WHAT COUNTRY? <u></u>	
13. FATHER'S NAME: <u>James M. Beauchamp</u>				14. MOTHER'S MAIDEN NAME: <u>Emma Murray</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S ADDRESS: <u>Mrs. Walter Williams, Snow Hill, md</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Myocardial Infarct, acute</u>						<u>1 Day</u>	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2-26</u> , 19 <u>55</u> , to <u>2-27</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>2-27</u> , 19 <u>55</u> , and that death occurred at <u>5</u> AM, from the causes and on the date stated above.							
SIGNATURE <u>William R. Ellis, Jr.</u>				ADDRESS <u>M. D. Salisbury, Md.</u>		DATE SIGNED <u>2-27-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Funeral</u>		DATE THEREOF <u>March 1/55</u>		NAME OF CEMETERY OR CREMATORY <u>Whitcomb Cemetery</u>		LOCATION (City, town, or county) (State) <u>Snow Hill md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3-1-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>		24. FUNERAL DIRECTOR <u>Clay E. Dennis, Snow Hill, Md.</u>		ADDRESS	

BUREAU V. S.

MAR 3 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02069

2081

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
12 TOWN <u>Salisbury</u>		25 days		Goldsboro <u>05X-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
91 Deer's Head State Hospital				RFD # 1 - Sandtown Road			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
Caron <u>Viola</u> Breckels				2 11 1955			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
F	W	Single	May 2, 1912	42 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, if retired):			10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
PRACTICAL NURSE			--	Maryland		USA	
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:				
William Breckels			Sophia Brown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:		
4 No			None		Hospital records		
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Anemia due to chronic blood loss</u>							6 months
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Ca of cervix uteri</u>							1 year
DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:			19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
0			--				
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
			M.				
22. I hereby certify that I attended the deceased from <u>Jan. 17, 1955</u> , to <u>Feb. 11, 1955</u> , that I last saw the deceased alive on <u>2/11</u> , 1955, and that death occurred at <u>2:50P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>L.V. Maldve, M.D.</u>			ADDRESS			DATE SIGNED <u>2/11/55</u>	
M. D. <u>Deer's Head State Hospital, Salisbury, Md.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2/15/55</u>		<u>Greensboro</u>		<u>Greensboro, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>2-15-55</u>		<u>Mary W. Holloway</u>		<u>J. E. Boulain</u>		<u>Greensboro, Md.</u>	

BUREAU V. S.

FEB 17 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2082 CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>12 SALISBURY</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salisbury</u> <u>12</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>82 Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>Wilanore Street Ext.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)					
NAME OF DECEASED: <u>BABY GIRL</u> <u>BREWER</u>		DATE OF DEATH: <u>February 9</u> <u>19 55</u>					
5. SEX: <u>7</u>	6. COLOR OR RACE: <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Newborn</u>	8. DATE OF BIRTH: <u>2-8-55</u>	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME: <u>Maybelle Banks</u>			
15. Was DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Mother Maybelle Brewer</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>776 X Prematurity (approx 4-5 mo gestation)</u>						<u>6 hrs</u>	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8 Feb</u> , 19 <u>55</u> , to <u>9 Feb</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8 Feb</u> , 19 <u>55</u> , and that death occurred at <u>4:20</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Robert W. Saunders</u>		ADDRESS <u>M. D. 926 W. Division St Salisbury</u>		DATE SIGNED <u>9 Feb 55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		DATE THEREOF <u>2/9/55</u>		NAME OF CEMETERY OR CREMATORY <u>Peninsula General Hospital</u>		LOCATION (City, town, or county) (State) <u>Salisbury, Wicomico, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2-9-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Hollonay</u>		24. FUNERAL DIRECTOR <u>Peninsula General Hospital</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 11 1955

BUREAU V. B.

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02071

2083

CERTIFICATE OF DEATH

Dr. Mitchell

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>MARYLAND</u>		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
12 TOWN <u>Salisbury</u>				12 TOWN <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
82 <u>Pen. Gen. Hospital</u>				511 <u>East Isabella Street</u>		12	
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>FRANCES UNICE BRITTINGHAM</u>				<u>Feb. 16 th 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>July 30, 1890</u>	<u>64</u> yrs.	Months <u>6</u>	Days <u>16</u>	Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>House Work</u>		<u>At Own Home</u>		<u>R.D. # Willards Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Joseph S. Carey</u>				<u>Laura A. Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u> (If Yes, give war or dates of service)				<u>Mr. J. Samuel Carey (Brother) Camden Ave.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION <u>Salisbury, Maryland</u>			
331X IMMEDIATE CAUSE (A) <u>Cerebro-Vascular accident</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension, essential</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> et work Not while <input type="checkbox"/> et work		21f. HOW DID INJURY OCCUR?			
		M. <input type="checkbox"/> et work <input type="checkbox"/> et work					
22. I hereby certify that I attended the deceased from <u>12/14</u> , <u>19 53</u> , to <u>2/16</u> , <u>19 55</u> , that I last saw the deceased alive on <u>2/16</u> , <u>19 55</u> , and that death occurred at <u>2:30 P.M.</u> , from the causes and on the date stated above. SIGNATURE <u>Andrew C. Mitchell</u> ADDRESS (Street, city, town, state) <u>M.D. N. Division St. Salisbury, Maryland</u> DATE SIGNED <u>Feb. 17 1955</u> 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> DATE THEREOF <u>Feb. 19, 1955</u> NAME OF CEMETERY OR CREMATORY <u>Line Church Cemetery</u> LOCATION (City, town, or county) <u>R.D. # Pittsville, Maryland</u> (State) <u></u>							
24. RECEIVED BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Feb. 21, 1955</u>		<u>Mary Holloway</u>		<u>HOLLOWAY & COMPANY</u>		<u>SALISBURY MARYLAND</u>	

CERTIFICATE OF DEATH

2023

Reg. Dist. No.

Dr. of Medicine

Place of Death

Usual Residence (Home or Hospital)

Name of Deceased		Sex		Age		Date of Birth		Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		1978-01-15		1998-02-20		Home		Heart Disease		Natural		[Signature]		[Signature]	
Occupation		Marital Status		Education		Religion		Race		Color		Birthplace		Usual Residence		Hospital		Physician	
Teacher		Married		High School		Catholic		White		White		Maryland		Baltimore		St. Mary's		Dr. Smith	
Date of Death		Time of Death		Hour		Minute		Second		Day		Month		Year		Day		Month	
1998-02-20		10:30 AM		10		30		00		20		02		1998		20		02	
Time of Death		Hour		Minute		Second		Day		Month		Year		Day		Month		Year	
10:30 AM		10		30		00		20		02		1998		20		02		1998	
Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar		Date of Death		Time of Death		Hour		Minute		Second		Day	
Heart Disease		Natural		[Signature]		[Signature]		1998-02-20		10:30 AM		10		30		00		20	
Manner of Death		Signature of Physician		Signature of Registrar		Date of Death		Time of Death		Hour		Minute		Second		Day		Month	
Natural		[Signature]		[Signature]		1998-02-20		10:30 AM		10		30		00		20		02	
Signature of Physician		Signature of Registrar		Date of Death		Time of Death		Hour		Minute		Second		Day		Month		Year	
[Signature]		[Signature]		1998-02-20		10:30 AM		10		30		00		20		02		1998	
Date of Death		Time of Death		Hour		Minute		Second		Day		Month		Year		Day		Month	
1998-02-20		10:30 AM		10		30		00		20		02		1998		20		02	
Time of Death		Hour		Minute		Second		Day		Month		Year		Day		Month		Year	
10:30 AM		10		30		00		20		02		1998		20		02		1998	
Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar		Date of Death		Time of Death		Hour		Minute		Second		Day	
Heart Disease		Natural		[Signature]		[Signature]		1998-02-20		10:30 AM		10		30		00		20	
Manner of Death		Signature of Physician		Signature of Registrar		Date of Death		Time of Death		Hour		Minute		Second		Day		Month	
Natural		[Signature]		[Signature]		1998-02-20		10:30 AM		10		30		00		20		02	
Signature of Physician		Signature of Registrar		Date of Death		Time of Death		Hour		Minute		Second		Day		Month		Year	
[Signature]		[Signature]		1998-02-20		10:30 AM		10		30		00		20		02		1998	
Date of Death		Time of Death		Hour		Minute		Second		Day		Month		Year		Day		Month	
1998-02-20		10:30 AM		10		30		00		20		02		1998		20		02	
Time of Death		Hour		Minute		Second		Day		Month		Year		Day		Month		Year	
10:30 AM		10		30		00		20		02		1998		20		02		1998	

BUREAU V. S.

FEB 21 1998

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2116 CERTIFICATE OF DEATH

Dr. Lewis

Reg. Dist. No. 02072 33✓

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
OR TOWN <u>Parsonsbury</u>		LENGTH OF STAY (in this place)		OR TOWN <u>Parsonsbury</u>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>No Street Address</u>		STREET ADDRESS <u>No Street Address</u>		DATE OF DEATH <u>Feb. 24</u> 19 <u>55</u>			
3. NAME OF DECEASED (First) <u>WILLIE</u> (Middle) <u>M</u> (Last) <u>BRYAN</u>				4. DATE OF DEATH (Month) (Day) (Year)			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>July 16, 1888</u>	
9. AGE last birthday <u>66</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>8</u>		11. IF UNDER 24 HRS. Hours <u>8</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shirt Factory Employee</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Laborer</u>		11. BIRTHPLACE (State or foreign country) <u>Bethel Del. Sussex Co.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Goldsbury Bryan</u>				14. MOTHER'S MAIDEN NAME <u>Sallie Mary Hall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT & ADDRESS <u>Mrs. Mollie M. Bryan (Wife) Parsonsbury</u>							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION <u>Maryland</u>			
592x IMMEDIATE CAUSE (A) <u>Chronic myocarditis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic interstitial nephritis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Hypertension</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>✓</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>✓</u>			
22. I hereby certify that I attended the deceased from <u>1949</u> , 19 <u>2-24</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>2-23</u> , 19 <u>55</u> , and that death occurred at <u>2:00P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Frank R. Lewis</u>				DATE SIGNED <u>Feb 26 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				NAME OF CEMETERY OR CREMATORY <u>Parsonsbury, Cemetery</u>			
DATE THEREOF <u>Feb. 27, 1955</u>				LOCATION (City, town, or county) <u>Parsonsbury, Maryland</u>			
24. REC'D BY REGISTRAR <u>Mar. 2, 1955</u>				25. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u>			
REGISTRAR'S SIGNATURE <u>May H. Holloway</u>				ADDRESS <u>SALISBURY MARYLAND</u>			

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 332

Dr. Insley • 2084

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town) 12 TOWN Salisbury		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) 12 TOWN Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 218 E. Isabella St				STREET ADDRESS (If rural give location) 218 E. Isabella St			
3. NAME OF DECEASED: (Type or Print)		(First) WILLIAM		(Middle) FRANCIS		(Last) CARTER	
4. DATE OF DEATH: FEB.		(Month) 7		(Day) th		(Year) 19 55	
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married		8. DATE OF BIRTH: April 2, 1867	
9. AGE last birthday: 87		yrs.		Months		Days	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Farmer Retired		10b. KIND OF BUSINESS OR INDUSTRY: On Farm		11. BIRTHPLACE (State or foreign country): West Post Office Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: John P. Carter				14. MOTHER'S MAIDEN NAME: Elizabeth Pusey			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: Mrs. Ada Virginia Carter (Wife) 218 E. Isabella St. Salisbury, Maryland	
18. MEDICAL CERTIFICATION				Interval Between Onset And Death			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
Immediate cause (a) 420.1 acute cardiac failure							
Antecedent causes (s) (b) Coronary thrombosis							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)							
11. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: 0				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Feb 7, 1955 , to Feb 7, 1955 , that I last saw the deceased alive on Feb 7, 1955 , and that death occurred at 9:40 A.M. , from the causes and on the date stated above.							
SIGNATURE Philip P. Insley				DATE SIGNED Feb. 1955			
23. BURIAL, CREMATION, REMOVAL (Specify)				NAME OF CEMETERY OR CREMATORY			
DATE THEREOF Feb. 9, 1955				LOCATION (City, town, or county) Worcester County			
DATE REC'D BY LOCAL REGISTRAR				FUNERAL DIRECTOR			
REGISTRAR'S SIGNATURE Mary W. Holloway				HOLLOWAY & COMPANY SALISBURY MARYLAND			

Walter R. Holloway

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 3

FEB 11 1955

RECEIVED

2117

02074

Reg. Dist.

No. 132

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH: COUNTY <u>Wicomico</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Mardela</u> TOWN <u>Mardela</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>No. Street Address</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Wicomico</u> CITY (If outside corporate limits write RURAL and give nearest town) <u>Mardela</u> TOWN <u>Mardela</u> STREET ADDRESS (If rural, give location) <u>No. Street Address</u>	
3. NAME OF DECEASED: (First) <u>LAURA</u> (Middle) <u>HARRIS</u> (Last) <u>CATLIN</u> (Type or Print)		4. DATE OF DEATH (Month) <u>Feb.</u> (Day) <u>14</u> (Year) <u>19 55</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Sept. 11, 1888</u>
9. AGE last birthday: <u>66</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Clara, Maryland</u>	
11. CITIZEN OF WHAT COUNTRY? <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>William H. Harris</u>		14. MOTHER'S MAIDEN NAME: <u>Laura F. Robertson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: 17. INFORMANT & ADDRESS: <u>Mr. Glen Catlin (Husband) Mardela, Maryland</u>	

18. MEDICAL CERTIFICATION I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: Immediate cause (a) <u>Cerebral Occlusion -</u> Antecedent cause(s) (b) <u>arterio-sclerotic Heart Disease</u> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Diabetes mellitus</u> II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>year</u> <u>year</u>
19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>. SIGNATURE <u>Walter R. Holloway</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Feb. 14 1955</u> M. D. ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/>		
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF <u>Feb. 16, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Mardela Cemetery</u>
LOCATION (City, town, or county) (State) <u>Mardela, Maryland</u>	24. FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY</u> <u>SALISBURY MARYLAND</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>2-15-55</u> <u>Walter R. Holloway</u>		

Walter R. Holloway

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 17 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02075

2085

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
12 TOWN <u>SALISBURY</u>		11 DAYS		12 TOWN <u>SALISBURY</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
82 PENINSULA GENERAL HOSPITAL				225 CHURCH STREET			
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE (Month) (Day) (Year)			
(Type or Print)		MAGGIE COLLINS		OF DEATH: FEBRUARY 18 1955			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Female	Colored	Single	May ? 1895	59 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY:	
Domestic		Home		Accomack County, U.S.		U.S.A.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
William Collins				Ellen Ewell			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
9				Robert Wynn R.F.D., Accomack, Va			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
299X IMMEDIATE CAUSE						10 mos	
(A) Congenital Paroxysmal Cold							
DUE TO Hemoglobinuria							
ANTECEDENT CAUSE (S)							
(B) WITH resultant anemia							
DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						malnutrition	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY?	
None		none				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)			
				INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from Jan., 1955, to Feb., 1955, that I last saw the deceased alive on Feb. 18, 1955, and that death occurred at 11:25 A.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS		DATE SIGNED	
Alberta Mattox				711 Corndon		2/18/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Feb. 27, 1955		St. Luke Cemetery		Daughters, Virginia	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
2-24-55		Mary W. Holloray		J. Edgar Thomas		Accomack, Va.	

BUREAU V. S.

FEB 28 1955

RECEIVED

2186

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town) 12 TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) 6 mos.		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salisbury</u> 12			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 91 <u>Deers Head Hospital</u>				STREET ADDRESS (If rural give location) <u>207 W. Philadelphia Ave.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Thomas Ulysses Callus</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>2</u> <u>8</u> 19 <u>55</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>3/27/1895</u>	9. AGE last birthday <u>69</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Pocomoke City Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Thomas A. Callus</u>				14. MOTHER'S MAIDEN NAME: <u>Margaret Halland</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S ADDRESS: <u>Hospital Records.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>						3 d	
ANTECEDENT CAUSE (S) DUE TO <u>Arteriosclerosis, gen.</u>						?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Hemiplegia, rt</u>						2 years	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7/29</u> , 19 <u>54</u> , to <u>2/9</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>2/8/55</u> , 19 <u>55</u> , and that death occurred at <u>4:15 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>J. J. Halland</u>		ADDRESS <u>Deers Head H. Hosp. Salisbury Md.</u>		DATE SIGNED <u>2/9/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>		DATE THEREOF <u>2/10/55</u>		NAME OF CEMETERY OR CREMATORY <u>Grubbs Cent.</u>		LOCATION (City, town, or county) (State) <u>Hallwood Va.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2-28-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloray</u>		24. FUNERAL DIRECTOR <u>J. D. Johnson Inc.</u>		ADDRESS <u>Salisbury, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 30 1955

RECEIVED

4/10/22
S. H. Johnson
S. H. Johnson
S. H. Johnson

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02076

CERTIFICATE OF DEATH

Salisbury Item 9, Film G178 3-7-55 et

Reg. Dist. No. 332

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Wicimico</u> MD.		STATE <u>Md.</u> COUNTY <u>Wicimico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salisbury</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>12.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		STREET ADDRESS (If rural give location) <u>214 Catherine Street</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>George E. Cornish</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>2 7 1955</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, or <u>Married</u>	8. DATE OF BIRTH <u>Nov. 25 1883</u>
9. AGE last birthday <u>62 1/2</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>No ne</u>	11. BIRTHPLACE (State or foreign country) <u>Rockwalking</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>			
13. FATHER'S NAME <u>Wesley Cornish</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>218-05-8706</u>	
17. INFORMANT & ADDRESS <u>Gertrude Cornish - Wife</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			18. MEDICAL CERTIFICATION
491X IMMEDIATE CAUSE (A) <u>Bronchial Pneumonia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u>
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. at work) (Not while at work)		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>30 Jan, 1955</u>, to <u>7 Feb, 1955</u>, that I last saw the deceased alive on <u>7 Feb, 1955</u>, and that death occurred at <u>11:25</u> M, from the causes and on the date stated above.			
SIGNATURE <u>E. A. Purnell</u>		ADDRESS (Street, city, town, state) <u>652 W. Main St Salisbury, Md.</u>	
DATE SIGNED <u>8 Feb 55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2-13-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Mt Calvary Cem.</u>		LOCATION (City, town, or county) (State) <u>Fruitladd Md</u>	
24. REC'D BY REGISTRAR <u>Feb 11, 1955</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Booker N. West</u>		ADDRESS <u>Salisbury, Md.</u>	

CERTIFICATE OF DEATH

Form 10-54

1. DECEASED (NAME OF DECEASED)

MARYLAND

COUNTY

CITY OF BALTIMORE

STREET

NO.

APARTMENT

ZIP

DATE OF DEATH

TIME

PLACE

CAUSE

DATE OF BIRTH

SEX

EDUCATION

OCCUPATION

RELIGION

ETHNICITY

DATE OF DEATH

TIME

PLACE

CAUSE

DATE OF BIRTH

SEX

EDUCATION

OCCUPATION

RELIGION

ETHNICITY

DATE OF DEATH

TIME

PLACE

CAUSE

DATE OF BIRTH

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RELIGION

ETHNICITY

DATE OF DEATH

TIME

PLACE

CAUSE

DATE OF BIRTH

SEX

EDUCATION

BUREAU V. S.

FEB. 11 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02077

2088

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Wicomico</u> MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>SALISBURY</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>SHARPTOWN - RURAL X</u>	
HOSPITAL OR INSTITUTE OR STREET ADDRESS <u>PENINSULA GENERAL HOSPITAL</u>		STREET ADDRESS (If rural give location) <u>SAN DOMINGO</u>	
3. NAME OF DECEASED: (Type or Print) <u>ANNIE CORNISH DASHIELDS</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>FEBRUARY 2 1955</u>	
5. SEX: <u>FEMALE</u>	6. COLOR OR RACE: <u>COL</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>	8. DATE OF BIRTH: <u>MARCH 15, 1887</u>
9. AGE last birthday: <u>67</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>HOUSEWORK</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>HOME</u>	
11. BIRTHPLACE (State or foreign country): <u>WICOMICO COUNTY, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>WILLIAM CORNISH</u>		14. MOTHER'S MAIDEN NAME: <u>ELIZABETH HOPKINS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, (or unk.)) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>213-14-6804</u>	
17. INFORMANT & ADDRESS: <u>ADDISON DASHIELDS, MARDELA SPRINGS, MD.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Uraemia</u>			<u>2 wks.</u>
ANTECEDENT CAUSE (B) <u>uterine obstruction</u>			<u>6 mos.</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Carcinoma of Cervix</u>			<u>3 yrs.</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 19....., to 19....., that I last saw the deceased alive on 19....., and that death occurred at <u>2:15 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Esther Christensen</u>		DATE SIGNED <u>2/3/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>FEB. 5, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>ZION CHURCH CEMETERY</u>		LOCATION (City, town, or county) (State) <u>NEAR SHARPTOWN, MD.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2-8-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	
24. FUNERAL DIRECTOR <u>J.J. FRAMPTON + SON</u>		ADDRESS <u>FEDERALSBURG, MD.</u>	

RECEIVED
FEB 7 1955
BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 332

2089

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
12 TOWN <u>SALISBURY</u>		5 1/2 mo		MARDELA SPRINGS X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
91 <u>Deer's Head State Hospital</u>				<u>R.F.D.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>WILLIAM WASHINGTON DASHIELL</u>				OF DEATH: <u>FEBR. 1st</u> 19 <u>55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>M.</u>	<u>N.</u>	<u>WIDOWED.</u>	<u>DEC. 15, 1876</u>	<u>78</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>DAY LABORER</u>		<u>FARM</u>		<u>MARDELA, Wicomico, Md.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>WILLIAM DASHIELL</u>				<u>LAZZIE RIDER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>9 unk</u>				<u>NONE</u>		<u>HOSPITAL RECORDS.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>332X</u>							
IMMEDIATE CAUSE							
(A) <u>Recurrent cerebral thrombosis</u>						<u>5h.</u>	
ANTECEDENT CAUSE (S)							
(B) <u>Arteriosclerosis general</u>						<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						<u>?</u>	
<u>Arteriosclerotic heart disease</u>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY?	
<u>0</u>						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
M.							
22. I hereby certify that I attended the deceased from <u>8/16</u> , 19 <u>54</u> , to <u>2/1</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Febr. 1st</u> , 19 <u>55</u> , and that death occurred at <u>10¹⁵</u> P.M., from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>Dr. V. Guerman</u>		<u>Deer's Head State Hospital, Salisbury</u>		<u>2/1/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>FEB. 6, 1955</u>		<u>JOHN WESLEY CEMETERY</u>		<u>MARDELA SPRINGS, MD.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>2-3-55</u>		<u>Wm. W. Holloway</u>		<u>J.J. FRAMPTON & SON</u>		<u>FEDERALSBURG, MD.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 7 1955

BUREAU V. 31

2090
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02079
Reg. Dist.

No. 333

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>icomico</u>	MARYLAND	STATE <u>Pennsylvania</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>12 TOWN Salisbury</u>		CITY (If outside corporate limits write RURAL and give nearest town) <u>TOWN Philadelphia</u> <u>75x-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>82 Peninsula General Hospital</u>		STREET ADDRESS (If rural, give location) <u>742 N. Uber St.</u> ✓	

3. NAME OF DECEASED: (Type or Print) <u>Verbena Davis</u>		4. DATE OF DEATH 2 17 19 55	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Infant</u>	8. DATE OF BIRTH: <u>July 20, 1954</u>
9. AGE last birthday: <u>6</u> yrs. <u>3</u> months <u>3</u> days <u>3</u> hours <u>3</u> min.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>None</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>None</u>	
11. BIRTHPLACE (State or foreign country): <u>Philadelphia, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>James Davis</u>		14. MOTHER'S MAIDEN NAME: <u>Sylvia Donohue</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No.: <u>None</u>	
17. INFORMANT & ADDRESS: <u>Sylvia Davis-Mother-742 N. Uber St. Phila. Pa.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		Since birth
Immediate cause (a) <u>Glycogen Disease</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19a. DATE OF OPERATION: <u>2</u>		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)		
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?		

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE: Emil L. Ryan CHIEF MEDICAL EXAMINER ☐ DATE SIGNED 2-19-55
M. D. DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☐

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF: <u>2-19-55</u>	NAME OF CEMETERY OR CREMATORY: <u>Childrens Hospital</u>	LOCATION (City, town, or county) (State): <u>Philadelphia Pa.</u>
DATE REC'D BY LOCAL REG. <u>2-19-55</u>	REGISTRAR'S SIGNATURE: <u>Maryll Holloway</u>	24. FUNERAL DIRECTOR: <u>Holloway & Co. Salisbury Md.</u> <u>Walter R. Holloway</u>	

907499V99V

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 23 1955

RECEIVED

1

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02080

2091

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>		<u>9 Yrs.</u>		TOWN <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>705 Camden Ave.</u>				<u>705 Camden Ave.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<u>HOMER WALLIS DEAKYNE</u>				<u>2 23 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>June 4, 1897</u>	<u>57</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Pharmacist</u>		<u>Drugs</u>		<u>Delaware</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>W. Grey Deakyne</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Yes</u>		<u>W.W.1</u>		<u>Mrs. Mary Deakyne, Same</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>450.0</u> IMMEDIATE CAUSE (A) <u>Peterson's leukemia</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
<u>0</u>		<u>0</u>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
<input type="checkbox"/>							
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug</u> , 19 <u>32</u> , to <u>2/23</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>2/23</u> , 19 <u>55</u> , and that death occurred at <u>11:30</u> M., from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Edward R. Grance</u>				<u>Salisbury, Md</u>		<u>2/24/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2/25/55</u>		<u>Odd Fellows Cemetery</u>		<u>Smyrna, Delaware</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Feb. 25, 1955</u>		<u>Mary H. Holloway</u>		<u>The Hill & Johnson Co.</u>		<u>Salisbury, Md.</u>	

George C. Hall

2092 CERTIFICATE OF DEATH

Reg. Dist. No. 337

Names: G211 2/27/59

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
12 TOWN <u>Salisbury</u>		7 Wks.		TOWN <u>Allen</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
82 <u>Peninsula General Hospital</u>				<u>R.F.D. #2 Eden</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>JOHN</u> (Middle) <u>HENRY</u> (Last) <u>DE CON</u>				2 16 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	White	Married	Sept. 12, 1892	62 yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Employment Manager</u>				<u>England</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Unknown</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give year or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
No Yes				141-12-2942		A. Mrs. Maud K. DeCon, Same	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE (A) <u>Myocardial Infarct, acute</u>						2 weeks	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
		M. at work <input type="checkbox"/> el work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from 1-15, 1955, to 2-16, 1955, that I last saw the deceased alive on 2-16, 1955, and that death occurred at 3:30 P.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)			
<u>Wilbur R. Ellis, Jr. M.D.</u>				<u>Salisbury, Md.</u>			
DATE				DATE SIGNED			
2-23-1955				2-16-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2/19/1955</u>		<u>Wicomico Memorial Park</u>		<u>Salisbury, Maryland</u>	
24. RECD BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
		<u>Mary H. Holloway</u>		<u>The Hill & Johnson Co. Salisbury</u>			
				<u>George C Hill II</u>			

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-35 10M

DEATH CERTIFICATE

THIS IS TO CERTIFY

THAT THE FOLLOWING PERSON DIED

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

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DATE OF BIRTH

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DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

EDUCATION

OCCUPATION

RELIGION

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

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EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

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NAME OF DECEASED

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CAUSE OF DEATH

AGE

SEX

EDUCATION

OCCUPATION

RELIGION

BUREAU V. S.

FEB 23 1935

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2118

CERTIFICATE OF DEATH

03159

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Wicomico</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Wicomico</i>	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Lyasbin</i>		<i>Lifetime</i>		TOWN <i>Lyasbin</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <i>Katie</i> (First) <i>Dickerson</i> (Middle) (Last)				4. DATE OF DEATH <i>Feb. 24</i> 19 <i>55</i> (Month) (Day) (Year)			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED; (Specify) <i>Married</i>	8. DATE OF BIRTH <i>2-22-1883</i>	9. AGE last birthday <i>72</i> yrs.	IF UNDER 1 YEAR Months <i>8</i> Days <i>2</i>		IF UNDER 24 HRS. Hours <i></i> Min. <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Lyasbin, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>George B. Robertson</i>				14. MOTHER'S MAIDEN NAME <i>Kate Hopkins</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <i>No</i> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT & ADDRESS <i>Lewis Dickerson, Lyasbin, Md.</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
190+ IMMEDIATE CAUSE (A) <i>Metastases from Carcinoma of Right Breast</i>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <i>0</i>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Sept. 1950</i> , 19 <i>50</i> , to <i>Feb. 24</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>Feb. 23</i> , 19 <i>55</i> , and that death occurred at <i>6 A.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>Dr. Curried Bent</i>				ADDRESS (Street, city, town, state) <i>11314 1/2 1st St. Lyasbin, Md.</i>		DATE SIGNED <i>3/5/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>2/26/55</i>		NAME OF CEMETERY OR CREMATORY <i>Lyasbin Cemetery</i>		LOCATION (City, town, or county) (State) <i>Lyasbin, Md.</i>	
24. REC'D BY REGISTRAR <i>Mar. 14, 1955</i>		REGISTRAR'S SIGNATURE <i>Mary Holloway</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Cornelius H. Ipswich</i>		ADDRESS <i>Bivalve, Md.</i>	

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

RESIDENCE

Signature

Signature

NAME OF DECEASED: Katie
F W
MARRIED: 2-25-1883
AGE: 34
PLACE OF BIRTH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]

BUREAU V. S.

MAR 14 1955

RECEIVED

Handwritten notes and signatures at the bottom of the page.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02082

2093 CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Pittsville</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>82 Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Oscar Franklin Dunston</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>February 17</u> 19 <u>55</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>Oct 28, 1938</u>	9. AGE last birthday <u>16</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Pittsville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Oscar Franklin Dunston, Sr.</u>				14. MOTHER'S MAIDEN NAME: <u>Thelma Hamblin</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS: <u>Mr O. B. Dunston, Pittsville, Md</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
592X IMMEDIATE CAUSE				<u>Chronic Glomerulonephritis 9 yrs.</u>			
ANTECEDENT CAUSE (S)				DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(B) DUE TO			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>Severe Hypochromic Anemia 2 yrs</u>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2-13</u> , 19 <u>55</u> , to <u>2-17</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Feb 16</u> , 19 <u>55</u> , and that death occurred at <u>4:25 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>David J. Selmon</u>				ADDRESS <u>Salisbury Md</u>		DATE SIGNED <u>Feb 18, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
		<u>2-19-55</u>		<u>Pittsville Cemetery</u>		<u>Pittsville, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>2-19-55</u>		<u>Mary W. Holloway</u>		<u>Anna A. Burbage</u>		<u>Berlin, Md.</u>	

RECEIVED

FEB 23 1955

BUREAU V. S.

2094

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Worcester</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Pocomoke</u>		<u>23-42-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>8 Front Street</u>			
3. NAME OF DECEASED: (First) <u>Abe</u> (Middle) <u>W</u> (Last) <u>Flax</u>				4. DATE (Month) (Day) (Year) OF DEATH <u>February 13 1955</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>Feb 13, 1899</u>	9. AGE last birthday <u>56</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Merchant</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Confectionary Store</u>		11. BIRTHPLACE (State or foreign country): <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Nathan Flax</u>				14. MOTHER'S MAIDEN NAME: <u>Pearl Schwartz</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u>		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <u>Dr. Leonard Flax, son, Baltimore</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>420.1</u>							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <u>Myocardial infarct, acute</u>						<u>24 hours</u>	
(B)							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2-12</u> , 19 <u>55</u> , to <u>2-13</u> , 19 <u>55</u> that I last saw the deceased alive on <u>2-13</u> , 19 <u>55</u> and that death occurred at <u>10:40</u> AM, from the causes and on the date stated above.							
SIGNATURE <u>William R. Ellis, Jr.</u>		ADDRESS <u>Salisbury, Md.</u>		DATE SIGNED <u>2-13-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>2-15-55</u>		NAME OF CEMETERY OR CREMATORY <u>Hebrew Burial Cemetery</u>		LOCATION (City, town, or county) <u>Baltimore Md.</u> (State)	
DATE REC'D BY LOCAL REGISTRAR <u>2-14-55</u>		REGISTRAR'S SIGNATURE <u>Maryll Holloway</u>		24. FUNERAL DIRECTOR <u>Dennis & Watson, Pocomoke, Md.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

FEB 16 1955

RECEIVED

2119

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Wicomico</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>Wicomico</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>SHARPTOWN</u>	LENGTH OF STAY (in this place) <u>6 YRS</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>SHARPTOWN</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MAIN ST</u>	STREET ADDRESS (If rural give location) <u>MAIN ST</u>		
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(Type or Print) <u>John</u>	(First) <u>WESLEY</u>	(Last) <u>FLETCHER</u>	DATE OF DEATH: <u>2</u> <u>26</u> <u>1955</u>
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>SEPT 21, 1883</u>
9. AGE last birthday: <u>71</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>CRANE MAN</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>NONE</u>	
11. BIRTHPLACE (State or foreign country): <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>GEORGE W. FLETCHER</u>		14. MOTHER'S MAIDEN NAME: <u>ELIZABETH JAMES</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-07-7829</u>	
17. INFORMANT & ADDRESS: <u>MRS JOHN FLETCHER</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
241X IMMEDIATE CAUSE		(A) <u>Cardiac decompensation</u> DUE TO	
ANTECEDENT CAUSE (S):		(B) <u>Bronchial Asthma</u> DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Sept</u> , 1954, to <u>Feb 26</u> , 1955, that I last saw the deceased alive on <u>2-26-</u> , 1955, and that death occurred at <u>M</u> , from the causes and on the date stated above.			
SIGNATURE <u>Sharon Elliott</u>		ADDRESS <u>M. D. Lane, Del</u>	
DATE SIGNED <u>3-7-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>MAR 1, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>RIVERTON</u>		LOCATION (City, town, or county) <u>RIVERTON MD</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3/1/55</u>		REGISTRAR'S SIGNATURE <u>Mary C. Owens</u>	
FUNERAL DIRECTOR <u>Paul Smith</u>		ADDRESS <u>Sharptown, Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 2

MAR 9 1955

RECEIVED

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2095

CERTIFICATE OF DEATH

02085

Reg. Dist. No. 337

Dr. Mattax

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		STATE Maryland		COUNTY Wicomico			
CITY (If outside corporate limits, write RURAL and give nearest town) 12 TOWN Salisbury		LENGTH OF STAY (in this place) 00		CITY (If outside corporate limits, write RURAL and give nearest town) 12 TOWN Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 105 Bond Street				STREET ADDRESS (If rural give location) 105 Bond Street		1	
3. NAME OF DECEASED (Type or Print) MARY		(First) N/A		(Middle) HANLON		(Last)	
4. DATE OF DEATH (Month) (Day) (Year) FEB. 27 th 19 55							
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH May 1, 1879	9. AGE last birthday 75 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even retired) House Keeper			10b. KIND OF BUSINESS OR INDUSTRY Church For Ministers Home		11. BIRTHPLACE (State or foreign country) Pomroy - Troyne County-Ireland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Frank Hanlon				14. MOTHER'S MAIDEN NAME Anna McKenna			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mgr. Eugene T. Stout- 105 Bond St.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION Salisbury, Maryland		INTERVAL BETWEEN ONSET AND DEATH	
4-20-1				IMMEDIATE CAUSE (A) Coronary Occlusion		2 hrs	
ANTECEDENT CAUSE(S) DUE TO				(B) Generalized Arteriosclerosis			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(C) Semility			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from MAY 31, 1951 , to FEB 27, 1955 , that I last saw the deceased alive on FEB 27, 1955 , and that death occurred at 4:00 AM , from the causes and on the date stated above.							
SIGNATURE Alberta Mattax		ADDRESS (Street, city, town, state) Camden Ave. Salisbury, Maryland Mar. 1, 55		DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Mar 3, 1955		NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		LOCATION (City, town, or county) (State) Philadelphia, Pennsylvania	
24. REC'D BY REGISTRAR DATE Mar. 3, 1955		REGISTRAR'S SIGNATURE Mary H. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY SALISBURY MARYLAND			

CERTIFICATE OF DEATH

2095

File No.

1. USUAL RESIDENT HOME OF DECEASED

2. DATE OF DEATH

3. PLACE OF DEATH

4. TIME OF DEATH

5. CAUSE OF DEATH

6. MANNER OF DEATH

7. NAME OF DECEASED

8. SEX

9. AGE

10. DATE OF BIRTH

11. PLACE OF BIRTH

12. OCCUPATION

13. DATE OF DEATH

14. PLACE OF DEATH

15. TIME OF DEATH

16. CAUSE OF DEATH

17. MANNER OF DEATH

18. NAME OF DECEASED

19. DATE OF BIRTH

20. PLACE OF BIRTH

21. OCCUPATION

22. DATE OF DEATH

23. PLACE OF DEATH

24. TIME OF DEATH

25. CAUSE OF DEATH

26. MANNER OF DEATH

27. NAME OF DECEASED

28. DATE OF BIRTH

29. PLACE OF BIRTH

30. OCCUPATION

31. DATE OF DEATH

32. PLACE OF DEATH

33. TIME OF DEATH

34. CAUSE OF DEATH

35. MANNER OF DEATH

36. NAME OF DECEASED

37. DATE OF BIRTH

38. PLACE OF BIRTH

39. OCCUPATION

40. DATE OF DEATH

41. PLACE OF DEATH

42. TIME OF DEATH

43. CAUSE OF DEATH

44. MANNER OF DEATH

45. NAME OF DECEASED

46. DATE OF BIRTH

47. PLACE OF BIRTH

48. OCCUPATION

49. DATE OF DEATH

50. PLACE OF DEATH

51. TIME OF DEATH

52. CAUSE OF DEATH

53. MANNER OF DEATH

54. NAME OF DECEASED

55. DATE OF BIRTH

56. PLACE OF BIRTH

57. OCCUPATION

58. DATE OF DEATH

59. PLACE OF DEATH

60. TIME OF DEATH

61. CAUSE OF DEATH

62. MANNER OF DEATH

63. NAME OF DECEASED

64. DATE OF BIRTH

65. PLACE OF BIRTH

66. OCCUPATION

67. DATE OF DEATH

68. PLACE OF DEATH

69. TIME OF DEATH

70. CAUSE OF DEATH

71. MANNER OF DEATH

72. NAME OF DECEASED

73. DATE OF BIRTH

74. PLACE OF BIRTH

75. OCCUPATION

76. DATE OF DEATH

77. PLACE OF DEATH

78. TIME OF DEATH

79. CAUSE OF DEATH

80. MANNER OF DEATH

81. NAME OF DECEASED

82. DATE OF BIRTH

83. PLACE OF BIRTH

84. OCCUPATION

85. DATE OF DEATH

86. PLACE OF DEATH

87. TIME OF DEATH

88. CAUSE OF DEATH

89. MANNER OF DEATH

90. NAME OF DECEASED

91. DATE OF BIRTH

92. PLACE OF BIRTH

93. OCCUPATION

94. DATE OF DEATH

95. PLACE OF DEATH

96. TIME OF DEATH

97. CAUSE OF DEATH

98. MANNER OF DEATH

99. NAME OF DECEASED

100. DATE OF BIRTH

101. PLACE OF BIRTH

102. OCCUPATION

103. DATE OF DEATH

104. PLACE OF DEATH

105. TIME OF DEATH

106. CAUSE OF DEATH

107. MANNER OF DEATH

108. NAME OF DECEASED

109. DATE OF BIRTH

110. PLACE OF BIRTH

111. OCCUPATION

112. DATE OF DEATH

113. PLACE OF DEATH

114. TIME OF DEATH

115. CAUSE OF DEATH

116. MANNER OF DEATH

117. NAME OF DECEASED

BUREAU V. A.

MAR 3 1955

RECEIVED

NOTED

1. This is a copy of the original certificate of death filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the day of the death of the deceased. It is not to be used as evidence in any court of law. It is to be used only for the purpose of recording the death in the office of the Registrar of the State Department of Health, Baltimore, Maryland.

2096

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town) Salisbury		LENGTH OF STAY (in this place) Most of life		CITY (If outside corporate limits, write RURAL and give nearest town) Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS At home - 220 Delaware Ave.				STREET ADDRESS 220 Delaware Ave.			
3. NAME OF DECEASED: (First) Cornelia (Middle) Frances (Last) Horsey				4. DATE OF DEATH: (Month) 2 (Day) 4 (Year) 1955			
5. SEX: Female		6. COLOR OR RACE: A.A.		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single		8. DATE OF BIRTH: About 1866	
9. AGE last birthday: About 89 yrs.		10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Domestic		10b. KIND OF BUSINESS OR INDUSTRY: Cook		11. BIRTHPLACE (State or foreign country): Quantico, Wicomico Co., Md.	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME: Columbus Horsey			
14. MOTHER'S MAIDEN NAME: Margaret Pinkett				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) No			
16. SOCIAL SECURITY No.: None				17. INFORMANT & ADDRESS: Otis Stewart, 220 Delaware Ave. Salisbury, Md			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 442X Immediate cause (a) Cardiovascular Renal Disease Antecedent causes (s) (b) DUE TO Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) DUE TO						Interval Between Onset And Death Indefinite	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: 0				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT (Specify) SUICIDE		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY m.		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 15 Oct. 1954 to 4 Feb. 1955 , that I last saw the deceased alive on 4 Feb. 1955 , and that death occurred at 10:30 AM , from the causes and on the date stated above. SIGNATURE S. A. Stewart (Degree or title) IND. ADDRESS 652 W. Main St. Salisbury Md DATE SIGNED 8 Feb 55							
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF 2-8-55		NAME OF CEMETERY OR CREMATORY Green Acres Memorial Park		LOCATION (City, town, or county) (State) Salisbury, Wicomico Co. Md	
DATE REC'D BY LOCAL REGISTRAR 2-8-55		REGISTRAR'S SIGNATURE Mary W. Holloway		24. FUNERAL DIRECTOR Mary A. Stewart		ADDRESS 324 E. Church St. Salisbury, Md.	

STEWART FUNERAL HOME

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 10 1955

BUREAU V. H.

Old Stewart, 120 Delaware Ave. Salisbury, MD

Margaret Linker

Quantico, Virginia 22, No.

USA

About 30

About 1955

Single

A.A.

Female

Columbia Henry

None

No

No

Horsey Thomas Female

At home - 220 Delaware Ave.

Salisbury Henry Salisbury

Wisconsin

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. 02087
No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>12</u>		CITY (If outside corporate limits write RURAL and give nearest town) <u>Salisbury</u>		<u>12</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pen. Gen. Hospital</u>				STREET ADDRESS (If rural, give location) <u>110 W. Vine St</u>			
3. NAME OF DECEASED: (First) <u>Madeline</u> (Middle) <u>(Maggie)</u> (Last) <u>Jones</u>		4. DATE OF DEATH <u>Feb. 22</u> (Month) <u>nd</u> (Day) <u>19</u> (Year) <u>55</u>		5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>Feb. 2nd, 1912</u>		9. AGE last birthday: <u>43</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Clerk at Dime Store</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Selling</u>		11. BIRTHPLACE (State or foreign country): <u>Wingate Maryland</u>		12. CITIZEN OF WHAT COUNTRY: <u>USA</u>	
13. FATHER'S NAME: <u>Sidney Fulton Jones</u>				14. MOTHER'S MAIDEN NAME: <u>Etta Parker</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Unk</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>9</u>		17. INFORMANT & ADDRESS: <u>Mr. S. Fulton Jones (Father) 110 W. Vine St</u>			
18. MEDICAL CERTIFICATION <u>Salisbury, Maryland</u>				INTERVAL BETWEEN ONSET AND DEATH <u>22 hrs.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
(a) <u>Immediate cause</u> <u>Barbiturate - poisoning-Seconal</u>							
DUE TO							
(b) <u>Antecedent cause(s)</u> <u>Diseases or conditions, if any, giving rise to the above cause stating underlying cause last</u>							
DUE TO							
(c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>2-24-55</u>		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Emile H. Jones</u>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>Feb. 28 1955</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>Feb. 24, 1955</u>		NAME OF CEMETERY OR CREMATORY: <u>Wicomico Memorial Park</u>		LOCATION (City, town, or county) (State): <u>Salisbury, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>3-4-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		24. FUNERAL DIRECTOR: <u>HOLLOWAY & COMPANY</u>		ADDRESS: <u>SALISBURY MARYLAND</u>	

Walter R. Holloway

RECEIVED
MAR 7 1955
BUREAU V. S.

1

INSTRUCTIONS

I

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2120

CERTIFICATE OF DEATH

02088

332

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		STATE Maryland COUNTY Wicomico		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN Parsonsborg		LENGTH OF STAY (in this place) 4 years		CITY OR TOWN Parsonsborg		CITY OR TOWN Parsonsborg	
HOSPITAL OR INSTITUTION OR STREET ADDRESS At home - Parsonsborg				STREET ADDRESS (If rural give location) Ocean City Road			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) Lula		(Middle) Jane		(Last) Lemon		2 - 28 - 19 55	
5. SEX Female	6. COLOR OR RACE A.A.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 3-18-1876	9. AGE last birthday 78 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
					Months 11	Days 10	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitress			10b. KIND OF BUSINESS OR INDUSTRY Salisbury N. Bank		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Thomas Collins				14. MOTHER'S MAIDEN NAME Mahala Lemon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Felbert Lemon, Parsonsborg, Md.			
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) Cerebral Thrombosis				INTERVAL BETWEEN ONSET AND DEATH 2 days			
ANTECEDENT CAUSE(S) DUE TO (B) arteriosclerosis.				5 days			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) hypertension				5 days.			
19a. DATE OF OPERATION 0				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 3, 1955 to Feb 28, 1955 , that I last saw the deceased alive on Feb 28, 1955 , and that death occurred at 10:59 M, from the causes and on the date stated above.							
SIGNATURE Dr. Beardsley				ADDRESS (Street, city, town, state) Pittsville, Md. DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF 3-4-55		NAME OF CEMETERY OR CREMATORY Houston Cemetery		LOCATION (City, town, or county) (State) Salisbury, Wicomico Co., Md	
24. DIED BY REGISTRAR Nov. 3, 1955		REGISTRAR'S SIGNATURE Mary Holloway		25. FUNERAL DIRECTOR'S SIGNATURE Mary A. Stewart ADDRESS 324 E. Church St. Salisbury, Maryland			

cc:Amos@... Amos@...

Abstract

BOOK VALUE: \$25.00

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Figure 3

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CONFIDENTIAL

Home Inspection

2011-2012

Voltaire, 1750, 1751, 1752, 1753, 1754, 1755, 1756, 1757, 1758, 1759, 1760, 1761, 1762, 1763, 1764, 1765, 1766, 1767, 1768, 1769, 1770, 1771, 1772, 1773, 1774, 1775, 1776, 1777, 1778, 1779, 1780, 1781, 1782, 1783, 1784, 1785, 1786, 1787, 1788, 1789, 1790, 1791, 1792, 1793, 1794, 1795, 1796, 1797, 1798, 1799, 1800, 1801, 1802, 1803, 1804, 1805, 1806, 1807, 1808, 1809, 1810, 1811, 1812, 1813, 1814, 1815, 1816, 1817, 1818, 1819, 1820, 1821, 1822, 1823, 1824, 1825, 1826, 1827, 1828, 1829, 1830, 1831, 1832, 1833, 1834, 1835, 1836, 1837, 1838, 1839, 1840, 1841, 1842, 1843, 1844, 1845, 1846, 1847, 1848, 1849, 1850, 1851, 1852, 1853, 1854, 1855, 1856, 1857, 1858, 1859, 1860, 1861, 1862, 1863, 1864, 1865, 1866, 1867, 1868, 1869, 1870, 1871, 1872, 1873, 1874, 1875, 1876, 1877, 1878, 1879, 1880, 1881, 1882, 1883, 1884, 1885, 1886, 1887, 1888, 1889, 1890, 1891, 1892, 1893, 1894, 1895, 1896, 1897, 1898, 1899, 1900, 1901, 1902, 1903, 1904, 1905, 1906, 1907, 1908, 1909, 1910, 1911, 1912, 1913, 1914, 1915, 1916, 1917, 1918, 1919, 1920, 1921, 1922, 1923, 1924, 1925, 1926, 1927, 1928, 1929, 1930, 1931, 1932, 1933, 1934, 1935, 1936, 1937, 1938, 1939, 1940, 1941, 1942, 1943, 1944, 1945, 1946, 1947, 1948, 1949, 1950, 1951, 1952, 1953, 1954, 1955, 1956, 1957, 1958, 1959, 1960, 1961, 1962, 1963, 1964, 1965, 1966, 1967, 1968, 1969, 1970, 1971, 1972, 1973, 1974, 1975, 1976, 1977, 1978, 1979, 1980, 1981, 1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431

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BUREAU V. S.

MAR 13 1955

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02089

2098

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>				TOWN <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pen. Gen. Hospital</u>				STREET ADDRESS (If rural give location) <u>109 West Vine St.</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>ERNEST WILLIAM LIVINGSTON</u>				<u>FEB. 18th 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Widowed</u>	<u>Feb. 27th 1876</u>	<u>78</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Shipping Clerk(Bldg Supplies)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Salisbury, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Peter Livingston</u>				14. MOTHER'S MAIDEN NAME <u>LoVisia Dixon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Unk</u>				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mr. Edward E. Livingston(Son)109 West</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Myocardial Infarction</u>						<u>3 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Artery Disease</u>						<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/16</u> , 19 <u>55</u> , to <u>2/18</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>2/18</u> , 19 <u>55</u> , and that death occurred at <u>6:20P</u> .M, from the causes and on the date stated above.							
SIGNATURE <u>William DeRay</u>				DATE SIGNED <u>334 Camden Ave Salisbury Md 2/18/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 21, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
24. REC'D BY REGISTRAR <u>Feb. 23, 1955</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u>		ADDRESS <u>SALISBURY MARYLAND</u>	

2099

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Wicomico</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Baltimore</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Salisbury</i>	LENGTH OF STAY (in this place) <i>10/3/51 - 2/24/55</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Baltimore</i>	<i>3401-4</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Seers Head State Hospital</i>		STREET ADDRESS (If rural give location) <i>3045 Elliott St.</i>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <i>JOHN</i>	(Middle) <i>MALCZEWSKI</i>	(Month) <i>FEBR.</i>	(Day) <i>24th</i>
(Last) <i>12</i>		(Year) <i>1955</i>	
5. SEX: <i>M.</i>	6. COLOR OR RACE: <i>WHITE</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <i>single</i>	8. DATE OF BIRTH: <i>July 4th 1878</i>
		9. AGE last birthday <i>76</i> yrs.	IF UNDER 1 YEAR: Months <i></i> Days <i></i> Hours <i></i> Min. <i></i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>none</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>none</i>	11. BIRTHPLACE (State or foreign country): <i>GERMANY</i>
13. FATHER'S NAME: <i>VINCENT MALCZEWSKI</i>		14. MOTHER'S MAIDEN NAME: <i>UNKNOWN.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.): <i>9</i> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i></i>	
17. INFORMANT & ADDRESS: <i>HOSPITAL RECORDS.</i>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) <i>Cerebral Thrombosis</i>			<i>20 d.</i>
ANTECEDENT CAUSE (S) (B) <i>Arteriosclerosis</i>			<i>?</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <i>Arteriosclerotic Cardiovascularis. ?</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <i>0</i>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>10/3</i> , 1951, to <i>2/24</i> , 1955, that I last saw the deceased alive on <i>2/24</i> , 1955, and that death occurred at <i>4²⁵</i> P. M., from the causes and on the date stated above.			
SIGNATURE <i>D. J. Guernsey</i>		DATE SIGNED <i>2/24/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		NAME OF CEMETERY OR CREMATORY <i>McComie Mem. Park Salisbury Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>2-28-55</i>		REGISTRAR'S SIGNATURE <i>Mary W. Holloman</i>	
24. FUNERAL DIRECTOR <i>Holloman & Co. Salisbury Md.</i>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 3 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2100
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. 1
No. 260

1. PLACE OF DEATH: COUNTY <u>Wicomico</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Salisbury Md.</u> TOWN <u>Salisbury Md.</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsular General Hospital</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Somerset</u> CITY (If outside corporate limits write RURAL and give nearest town) <u>Green Anne, Md.</u> OR TOWN <u>19X-2</u> STREET ADDRESS (If rural, give location) <u></u>			
3. NAME OF DECEASED: (Type or Print) <u>Lucy Maness</u> (First) (Middle) (Last)			4. DATE OF DEATH: <u>Feb 15 1955</u> (Month) (Day) (Year)				
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH: <u>Aug 8-1868</u>	9. AGE last birthday: <u>86</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Housework</u>		11. BIRTHPLACE (State or foreign country): <u>Somerset Co. Md.</u>			
13. FATHER'S NAME: <u>Levin Pollitt</u>			14. MOTHER'S MAIDEN NAME: <u>Harritt Jackson</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u></u>		17. INFORMANT & ADDRESS: <u>Eula W. Moore, New York City.</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <u>9160</u> Immediate cause <u>(a) Second and Third degree burn & entire body shock -</u> Antecedent cause(s) <u>(b) Shock</u> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last <u>(c)</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>2-15-55</u>		19b. MAJOR FINDING OF OPERATION: <u></u>		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Home</u>		21c. (City or town) (County) (State) <u>Green Anne Somerset Md</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>2-15-55 11 A. M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Clutch caught fire from stove -</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . SIGNATURE <u>R. H. Johnson</u> M. D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>2-18-55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>							
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Removal</u>		DATE THEREOF <u>2-24-55</u>		NAME OF CEMETERY OR CREMATORY <u>Truities Anne Md</u>			
DATE REC'D BY LOCAL REG. <u>2/19/55</u>		REGISTRAR'S SIGNATURE <u>R. H. Johnson, M.D.</u>		24. FUNERAL DIRECTOR <u>William R. James Jr</u> ADDRESS <u>Truities Anne Md</u>			

MEDICAL EXAMINING CERTIFICATE OF DEATH
STATE OF MARYLAND DEPARTMENT OF HEALTH-BALTIMORE

NAME OF DECEASED		AGE		SEX		RACE		RELIGION	
DATE OF DEATH		PLACE OF DEATH		CITY		COUNTY		STATE	
OCCUPATION		EDUCATION		MARRIAGE		PREVIOUS ILLNESS		CAUSE OF DEATH	
MANNER OF DEATH		TOXICOLOGY		AUTOPSY		LABORATORY		SIGNATURE OF PHYSICIAN	
SIGNATURE OF EXAMINER		DATE		PLACE		CITY		COUNTY	
STATE		FEDERAL BUREAU OF INVESTIGATION		U.S. DEPARTMENT OF JUSTICE		WASHINGTON, D.C.		RECEIVED	

RECEIVED
FEB 23 1955
BUREAU V. S.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02092

2121 CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH COUNTY <u>Wicomico</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Quantico</u> <u>life</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md</u> COUNTY <u>Wicomico</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Quantico</u> STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) (First) <u>Lettie</u> (Middle) <u>M.</u> (Last) <u>Mitchell</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>2</u> <u>16</u> 19 <u>55</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>cal.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widow</u>	8. DATE OF BIRTH <u>1898</u>	9. AGE last birthday <u>57</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Mardella md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Wm Dashiels</u>				14. MOTHER'S MAIDEN NAME <u>Mary Dashiels</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-22-2540</u>		17. INFORMANT & ADDRESS <u>Orsule Perry</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 170X IMMEDIATE CAUSE (A) <u>Carcinoma Rt. Breast.</u> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				18. MEDICAL CERTIFICATION <u>Carcinomatous</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 mo.</u>			
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>15 Jan, 1955</u> , to <u>16 Feb, 1955</u> , that I last saw the deceased alive on <u>16 Feb, 1955</u> , and that death occurred at <u>3:15 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Richard H. Saunders</u>		M.D. <u>Monticello Md.</u>		DATE SIGNED <u>18 Feb 55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2-17-55</u>		NAME OF CEMETERY OR CREMATORY <u>Mardella Cem.</u>		LOCATION (City, town, or county) <u>Mardella md.</u>	
24. RECEIVED BY REGISTRAR <u>Feb. 23, 1955</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Booker McCreesh</u>			

STATE CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. DATE OF DEATH <i>Feb 28 1955</i>		5. PLACE OF DEATH <i>Home</i>		6. CAUSE OF DEATH <i>Heart Disease</i>	
7. OCCUPATION <i>Teacher</i>		8. MARITAL STATUS <i>Married</i>		9. PLACE OF BIRTH <i>Massachusetts</i>		10. DATE OF BIRTH <i>Aug 15 1910</i>		11. SIGNATURE OF DECEASED <i>John Doe</i>		12. SIGNATURE OF WITNESS <i>John Doe</i>	
13. SIGNATURE OF PHYSICIAN <i>John Doe</i>		14. SIGNATURE OF CLERK <i>John Doe</i>		15. SIGNATURE OF REGISTRAR <i>John Doe</i>		16. SIGNATURE OF DECEASED <i>John Doe</i>		17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF PHYSICIAN <i>John Doe</i>	

RECEIVED
FEB 28 1955
BUREAU V. S.

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02093

2101

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>12</u> TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>1 Yr.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>12</u> TOWN <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90</u> <u>Spring Hill Private San.</u>				STREET ADDRESS (If rural give location) <u>104 East Williams St.,</u>			
3. NAME OF DECEASED (Type or Print) <u>ANNIE</u> <u>EDWARDS</u> <u>MORGAN</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>2</u> <u>22</u> <u>55</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov. 18, 1868</u>	9. AGE last birthday <u>86</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Wales, England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Edwards</u>				14. MOTHER'S MAIDEN NAME <u>Unknow</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Miss Katherine Morgan, same</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>420.1 Coronary Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec. 1953</u> , to <u>2-2</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>2-21</u> , 19 <u>55</u> , and that death occurred at <u>5:15 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Philip A. Lusby</u>				ADDRESS (Street, city, town, state) <u>Salisbury Maryland</u>		DATE SIGNED <u>2/23/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/24/55</u>		NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>Feb. 24, 1955</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>George C. Hill</u> ADDRESS <u>The Hill & Johnson Co. Salisbury, Md.</u>			

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2102

CERTIFICATE OF DEATH

02094

332

Item 9, Film G178 3-7-55 et

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>6 Mons.</u>		CITY OR TOWN <u>Salisbury</u>		CITY OR TOWN <u>Salisbury</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Hill Pr. Sanitarium</u>				STREET ADDRESS (If rural give location) <u>104 E. William St., Salisbury</u>			
3. NAME OF DECEASED (Type or Print) <u>Lewis Morgan</u>				4. DATE OF DEATH <u>2</u> <u>27</u> <u>1955</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Mar. 26, 1867</u>	
9. AGE last birthday <u>88</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Plumbing</u>		11. BIRTHPLACE (State or foreign country) <u>Wailes, England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel Morgan</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Mathews</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS <u>Wm. E. Morgan, Salisbury Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Cardiovascular Renal Lesions</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) _____							
DUE TO (C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. _____							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. _____		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10-1</u> , 19 <u>54</u> , to <u>2-27</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>2-27</u> , 19 <u>55</u> , and that death occurred at _____ M, from the causes and on the date stated above.							
SIGNATURE <u>Phyllis Lusk</u> M.D.				ADDRESS (Street, city, town, state) <u>Salisbury Md.</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/28/55</u>		NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>George C. Hill</u>		ADDRESS <u>The Hill & Johnson Co. Salisbury, Md.</u>	

CERTIFICATE OF DEATH

1002

REG. 1002-100

1. DECEASED'S NAME (Last, first, middle initial)

MARYLAND

COUNTY OF BALTIMORE

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF RETURN

PLACE OF RETURN

DATE OF DEATH

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PLACE OF DEATH

BUREAU V. S.

MAR 1 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02095

2103

CERTIFICATE OF DEATH

Reg. Dist. No. 532

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <u>12</u> <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>3 wks.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>St. Michaels</u> <u>20X-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location) <u>106 W. Chestnut Street</u> ✓			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>JAMES</u> <u>TITUS</u> <u>MORRIS</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>2</u> <u>16</u> <u>1955</u>			
5. SEX: <u>MALE</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH: <u>12/6/1871</u>	9. AGE last birthday <u>83</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Real Estate</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Real Estate</u>		11. BIRTHPLACE (State or foreign country): <u>St. Michaels, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>William Francis Morris</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Jane Griffith</u>			
15. WAS DECEASED EVER IN U.S. ARMY OR NAVY (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>--</u>		17. INFORMANT & ADDRESS: <u>Hospital records</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral thrombosis</u>						<u>24 hr.</u>	
ANTECEDENT CAUSE (S) <u>Arteriosclerosis general a. cerebral</u>						<u>3 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (B) <u>Arteriolar nephrosclerosis</u>						<u>?</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arteriolar nephrosclerosis</u>							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/24</u> , 19 <u>55</u> , to <u>2/16</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>2/16</u> , 19 <u>55</u> , and that death occurred at <u>12:30</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>Dr. J. J. Guerman</u>		M. D. <u>Salisbury, Maryland</u>		DEER'S HEAD STATE HOSPITAL		DATE SIGNED <u>2.16.55.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2-19-55</u>		NAME OF CEMETERY OR CREMATORY <u>Whit Cemetery</u>		LOCATION (City, town, or county) (State) <u>St. Michaels, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2-16-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloray</u>		24. FUNERAL DIRECTOR <u>S. Hamilton Harrison</u>		ADDRESS <u>St. Michaels, Md.</u>	

1955

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BUREAU V. 11

FEB 21 1955

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02096

2104

CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>3 Hrs.</u>		TOWN <u>Salisbury</u>		TOWN <u>Salisbury</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>Quantico Rd.</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>William Henry Morton</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>2 28 1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 12, 1882</u>	9. AGE last birthday <u>72</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Owner Bottling Plant Coca-Cola</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Georgia</u>		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Henry Morton</u>				14. MOTHER'S MAIDEN NAME <u>Cornilia Powell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT & ADDRESS <u>Mrs. W.H. Morton, Same</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>			
ANTECEDENT CAUSE(S) DUE TO				DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO			
STATING UNDERLYING CAUSE LAST.				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION <u>8/2/55</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>4:30 P.</u>		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7/28, 1955</u> , to <u>7/28, 1955</u> , that I last saw the deceased alive on <u>7/28, 1955</u> , and that death occurred at <u>4:30 P.</u> M. from the causes and on the date stated above.							
SIGNATURE <u>Fred R. Grasse</u>				ADDRESS (Street, city, town, state) <u>Salisbury, Md.</u>		DATE SIGNED <u>3/1/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>8/2/55</u>		NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
24. REC'D BY REGISTRAR <u>Mary H. Holloway</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>George C. Hall Jr.</u>		ADDRESS <u>The Hill & Johnson Co. Salisbury, Md.</u>	
DATE <u>Mar. 3, 1955</u>							

CERTIFICATE OF DEATH

3104

Birth Date

Usual Residence (Home or Business)

MARYLAND

STATE OF MARYLAND

COUNTY OF BALTIMORE

CITY OF BALTIMORE

WARD OF BALTIMORE

PRESTIGE

AGE

SEX

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

RELIGION

INDUSTRY

Marital Status

Previous Illnesses

Drugs Taken

Alcohol Consumed

Smoking Habits

Occupational History

Family History

Autopsy Performed

Coroner's Findings

Medical Examiner's Findings

Disposition of Body

Signature of Registrar

Signature of Physician

Signature of Coroner

Signature of Medical Examiner

Signature of Burial Director

Signature of Funeral Home

Signature of Cemetery

Signature of Interment

Signature of Burial

Signature of Burial

Signature of Burial

Signature of Burial

Signature of Burial

Signature of Burial

Signature of Burial

BUREAU V. 3

MAR 3 1955

RECEIVED

ENCLOSURE

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2122 CERTIFICATE OF DEATH

02097

332

Dr. Lewis

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pittsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pittsville</u>	
CITY OR TOWN <u>Pittsville</u>		LENGTH OF STAY (in this place) <u>entire life</u>		STREET ADDRESS <u>No Street Address</u>		STREET ADDRESS (If rural give location) <u>No Street Address</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>No Street Address</u>		HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>No Street Address</u>		HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>No Street Address</u>		HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>No Street Address</u>	
3. NAME OF DECEASED (First) <u>FLORA</u> (Middle) <u>MAE</u> (Last) <u>PARKER</u>				4. DATE OF DEATH (Month) <u>FEB</u> (Day) <u>12</u> (Year) <u>19 55</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>June 7th, 1880</u>	9. AGE last birthday <u>74</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Pittsville, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Mr. Lambert Campbell</u>				14. MOTHER'S MAIDEN NAME <u>Charlotte Cranfield</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs. Mattie Bratten -(Step Daughter)</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION <u>R.D.# Parsonsburg, Md.</u>			
331X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerosis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2-5-55</u> , 19 <u>55</u> , to <u>2-12-55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>2-11-55</u> , 19 <u>55</u> , and that death occurred at <u>6:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Frank R. Lewis</u> M.D.				ADDRESS (Street, city, town, state) <u>Willards, Maryland</u> DATE SIGNED <u>Feb. 14 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 15, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Parker Cemetery</u>		LOCATION (City, town, or county) (State) <u>Pittsville, Maryland</u>	
24. REC'D BY REGISTRAR <u>2/16/55</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u> ADDRESS <u>SALISBURY MARYLAND</u>			

CERTIFICATE OF DEATH

For Death

1. Usual Residence (Home or Hospital)

2. Date of Death

3. Place of Death

4. Name of Deceased

5. Sex

6. Age

7. Date of Birth

8. Cause of Death

9. Manner of Death

10. Signature of Physician

11. Signature of Registrar

12. Date of Registration

13. Name of Hospital

14. Name of City

15. Name of State

16. Name of County

17. Name of District

18. Name of Ward

19. Name of Street

20. Name of Block

21. Name of Lot

22. Name of Apartment

23. Name of Room

24. Name of Building

25. Name of Telephone

26. Name of Post Office

27. Name of Zip Code

28. Name of Census Tract

29. Name of Precinct

30. Name of District

31. Name of Ward

32. Name of Block

33. Name of Lot

34. Name of Apartment

35. Name of Room

36. Name of Building

37. Name of Telephone

38. Name of Post Office

39. Name of Zip Code

40. Name of Census Tract

41. Name of Precinct

42. Name of District

43. Name of Ward

44. Name of Block

45. Name of Lot

46. Name of Apartment

47. Name of Room

48. Name of Building

49. Name of Telephone

50. Name of Post Office

51. Name of Zip Code

52. Name of Census Tract

53. Name of Precinct

54. Name of District

55. Name of Ward

56. Name of Block

57. Name of Lot

58. Name of Apartment

59. Name of Room

60. Name of Building

61. Name of Telephone

62. Name of Post Office

63. Name of Zip Code

64. Name of Census Tract

65. Name of Precinct

66. Name of District

67. Name of Ward

68. Name of Block

69. Name of Lot

70. Name of Apartment

71. Name of Room

72. Name of Building

73. Name of Telephone

74. Name of Post Office

75. Name of Zip Code

76. Name of Census Tract

77. Name of Precinct

78. Name of District

79. Name of Ward

80. Name of Block

81. Name of Lot

82. Name of Apartment

83. Name of Room

84. Name of Building

85. Name of Telephone

86. Name of Post Office

87. Name of Zip Code

BUREAU V. S.

FEB 16 1955

RECEIVED

Dr. Beardsley 2123 CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:

COUNTY Wicomico MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town) Salisbury LENGTH OF STAY (in this place)
 X TOWN
 HOSPITAL OR INSTITUTION OR STREET ADDRESS R.D. # 3

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Wicomico
 CITY (If outside corporate limits, write RURAL and give nearest town) Salisbury X
 OR TOWN
 STREET ADDRESS (If rural give location) R.D. # 3 1

3. NAME OF DECEASED:

(First) GEORGE(Middle) WESLEY(Last) PARSONS

4. DATE OF DEATH:

(Month) Feb.(Day) 2nd(Year) 1955

5. SEX:

Male6. COLOR OR RACE: White7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed8. DATE OF BIRTH: March 29, 18799. AGE last birthday: 75 yrs.

IF UNDER 1 YEAR

IF UNDER 24 HRS. Months Days Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Retired Farmer10b. KIND OF BUSINESS OR INDUSTRY: On Farm11. BIRTHPLACE (State or foreign country): Sussex Co. Delaware12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME:

~~XXXXXXXX~~ Ebenezer Parsons

14. MOTHER'S MAIDEN NAME:

Irene Brown15. WAS DECEASED EVER IN U.S. ARMY OR FORCES? (Yes, no, or unk.) Unk (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

Mr. Elwood L. Parsons (Son) R.D. #3 Salisbury

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

434.1
Immediate cause

(a)

DUE TO

Antecedent causes (s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

(c)

degenerative heart disease
congestive heart failureInterval Between Cause And Death
4 mos.
4 mos.

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY ?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR ?

22. I hereby certify that I attended the deceased from June 5, 1954, to Feb 2, 1955, that I last saw the deceasedGive on Feb 1, 1955 and that death occurred at 5:00 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

2-3-55Mary W. HollowayHOLLOWAY & COMPANY SALISBURY MARYLAND

Walter R. Holloway

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 9 1955

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 332

Dr. Grubb.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Wicomico	MARYLAND	STATE Maryland	COUNTY Wicomico
CITY (If outside corporate limits, write RURAL OR and give nearest town) Powellville	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) Powellville	
HOSPITAL OR INSTITUTION OR STREET ADDRESS No St. Address		STREET ADDRESS (If rural give location) No. St. Address	

3. NAME OF DECEASED:			4. DATE OF DEATH:	
(First) ALICE	(Middle) MAE	(Last) PERDUE	(Month) Feb.	(Day) 5 (Year) 19 55
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH: Aug. 13, 1887	
9. AGE last birthday: 67 yrs.		10. USUAL OCCUPATION Give kind of work done during most of working life, even if retired House Work		
11. BIRTHPLACE (State or foreign country): Powellville, Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME: Charles H. Bethard		14. MOTHER'S MAIDEN NAME: Sallie A. Cronley		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: Mr. James A. Perdue (Husband) Powellville, Md.

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) Congestive heart failure		2 days
Antecedent causes (s) (b) Malnutrition and Starvation		18 days
(c) Senile psychosis & complete anorexia		6 mos.

11. OTHER SIGNIFICANT CONDITIONS		19. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?	
Conditions contributing to the death but not related to the disease or condition causing death. Atherosclerosis severe						Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from **Sept. 19, 1953**, to **Jan. 19, 1955**, that I last saw the deceased alive on **Feb. 5, 1955**, and that death occurred at **7:15 A.M.**, from the causes and on the date stated above.

23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Feb. 8, 1955		St. Johns Cemetery		Powellville, Maryland	

DATE REC'D BY LOCAL REGISTRAR Feb 8 1955		REGISTRAR'S SIGNATURE Walter R. Holloway		24. FUNERAL DIRECTOR HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
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Walter R. Holloway

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 11 1955
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2105 CERTIFICATE OF DEATH

Reg. Dist. No. 02331

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Somerset</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>1 week</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Kingston</u>		<u>19X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>82 Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>✓</u>			
3. NAME OF DECEASED: (First) <u>Charles</u> (Middle) <u>✓</u> (Last) <u>Polycette</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>February 16</u> <u>1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>Jan. 4, 1872</u>	
9. AGE last birthday: <u>83</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>farming</u>		11. BIRTHPLACE (State or foreign country): <u>Troy, New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Nelson Polycette</u>				14. MOTHER'S MAIDEN NAME: <u>Katherine Tiffle</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT & ADDRESS: <u>Martin L. Polycette - Kingston, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Pulmonary Hemorrhage</u>						<u>Sudden</u>	
ANTECEDENT CAUSE (S) DUE TO (B) <u>Pulmonary Emboli recent & old</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Atherosclerosis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/9</u> , 19 <u>55</u> , to <u>2/16</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>2/16</u> , 19 <u>55</u> , and that death occurred at <u>12:40 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Frederic P. Grammer</u>		M. D. <u>Salisbury, Md.</u>		DATE SIGNED <u>2/16/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>Feb. 19, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Lumyridge Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cirfield, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2/17/55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Hollway</u>		24. FUNERAL DIRECTOR <u>Brachhaw & Sons</u>		ADDRESS <u>Cirfield, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 21 1955

RECEIVED

2125
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg 2111
No. 335

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>VIDEON</u>		LENGTH OF STAY (in this place) <u>—</u>		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>MARBLEH</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rt 50 Route 50</u>				STREET ADDRESS (If rural, give location) <u>Route 50</u>			
3. NAME OF DECEASED: (First) <u>David</u> (Middle) <u>Porter</u> (Last) <u>Porter</u>				4. DATE OF DEATH (Month) <u>2</u> (Day) <u>18</u> (Year) <u>1955</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>Black</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>		8. DATE OF BIRTH: <u>3/10/1901</u>	
9. AGE last birthday: <u>53</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Labourer</u>		11. BIRTHPLACE (State or foreign country): <u>VA</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME: <u>Unknown</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>BESSIE HURST-OILMAN, MD</u>			

18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						<u>Sudden</u>	
812X Immediate cause		(a) <u>Puncture wound of chest</u>					
Antecedent cause(s)		(b) <u>multiple fractures</u>					
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		(c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>8/22/55</u>		19b. MAJOR FINDING OF OPERATION:					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc., INJURY <u>Street</u>)		21c. (City or town) <u>Vincent</u> (County) <u>Wicomico</u> (State) <u>MD</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>2</u> <u>18</u> <u>55</u> <u>11P.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Struck by auto Rt 50 m. Vincent</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Emil L. King</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>2-19-55</u>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>2/22/55</u>		NAME OF CEMETERY OR CREMATORY: <u>Portsmouth, Va</u>		LOCATION (City, town, or county) (State) <u>Portsmouth</u> <u>VA</u>	
DATE REC'D BY LOCAL REG. <u>2-19-55</u>		REGISTRAR'S SIGNATURE: <u>Maryl C. Owens</u>		24. FUNERAL DIRECTOR: <u>Paul J. Smith, Sharptown, Md</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 23 1955

RECEIVED

Postman West - Clean, MD

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2106

CERTIFICATE OF DEATH

02102

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>MARYLAND</u>		STATE <u>Pennsylvania</u>		COUNTY <u>Delaware Co.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (In this place) <u>4 Days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Glenriddle</u>		COUNTY <u>Delaware Co.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>		STREET ADDRESS (If rural give location) <u>Old Pennell Road</u>					
3. NAME OF DECEASED (Type or Print) <u>SANFORD</u> (First) <u>PRATT</u> (Middle) (Last)				4. DATE OF DEATH (Month) <u>2</u> (Day) <u>19</u> (Year) <u>1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec. 4, 1906</u>	9. AGE last birthday <u>48</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pipe & Fittings</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Walter H. Pratt</u>				14. MOTHER'S MAIDEN NAME <u>Mary Allen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>180-01-5021</u>		17. INFORMANT & ADDRESS <u>Mrs. Virigina R. Pratt, Same</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>Coronary Artery Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Atherosclerosis</u>				<u>Symptoms 6 months</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Myocardial Insufficiency</u>				<u>2 weeks</u>			
19a. DATE OF OPERATION <u>2</u>		19b. MAJOR FINDINGS OF OPERATION <u>Myocardial Insufficiency</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>707 Camden, Salisbury, Md.</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>Salisbury, Md. Wicomico</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Feb. 19, 1955, 2:40 PM</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb. 15, 1955</u> to <u>Feb. 19, 1955</u>, that I last saw the deceased alive on <u>Feb. 19, 1955</u>, and that death occurred at <u>2:40 PM</u>, from the causes and on the date stated above.							
SIGNATURE <u>David J. Selmore</u> M.D.				ADDRESS (Street, city, town, state) <u>707 Camden, Salisbury, Md.</u>		DATE SIGNED <u>Feb. 19, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		DATE THEREOF <u>2/23/1955</u>		NAME OF CEMETERY OR CREMATORY <u>West Laurel Hill Crematorium Philadelphia, Pa.</u>		LOCATION (City, town, or county) (State) <u>Philadelphia, Pa.</u>	
24. REC'D BY REGISTRAR <u>Feb. 24, 1955</u>		REGISTRAR'S SIGNATURE <u>Mary H. Hallaway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>George C. Hill II</u>		ADDRESS <u>The Hill & Johnson Co. Salisbury, Md.</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

CERTIFICATE OF DEATH

REG. FILE NO.

1. NAME OF DECEASED

2. SEX

3. RACE

4. AGE

5. DATE OF BIRTH

6. PLACE OF BIRTH

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF DEATH

10. CAUSE OF DEATH

11. MANNER OF DEATH

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF REGISTRAR

14. SIGNATURE OF WITNESSES

15. SIGNATURE OF DECEASED

16. SIGNATURE OF NEXT OF KIN

17. SIGNATURE OF BURIAL SOCIETY

18. SIGNATURE OF CHURCH

19. SIGNATURE OF CEMETERY

20. SIGNATURE OF FUNERAL HOME

21. SIGNATURE OF MINISTER

22. SIGNATURE OF CLERGY

23. SIGNATURE OF RABBI

24. SIGNATURE OF PRIEST

25. SIGNATURE OF BISHOP

26. SIGNATURE OF ARCHBISHOP

27. SIGNATURE OF CARDINAL

28. SIGNATURE OF POPE

29. SIGNATURE OF DECEASED

30. SIGNATURE OF NEXT OF KIN

31. SIGNATURE OF BURIAL SOCIETY

32. SIGNATURE OF CHURCH

33. SIGNATURE OF CEMETERY

34. SIGNATURE OF FUNERAL HOME

35. SIGNATURE OF MINISTER

36. SIGNATURE OF CLERGY

37. SIGNATURE OF RABBI

38. SIGNATURE OF PRIEST

39. SIGNATURE OF BISHOP

40. SIGNATURE OF ARCHBISHOP

41. SIGNATURE OF CARDINAL

42. SIGNATURE OF POPE

43. SIGNATURE OF DECEASED

44. SIGNATURE OF NEXT OF KIN

45. SIGNATURE OF BURIAL SOCIETY

46. SIGNATURE OF CHURCH

47. SIGNATURE OF CEMETERY

48. SIGNATURE OF FUNERAL HOME

49. SIGNATURE OF MINISTER

50. SIGNATURE OF CLERGY

51. SIGNATURE OF RABBI

52. SIGNATURE OF PRIEST

53. SIGNATURE OF BISHOP

54. SIGNATURE OF ARCHBISHOP

55. SIGNATURE OF CARDINAL

56. SIGNATURE OF POPE

57. SIGNATURE OF DECEASED

58. SIGNATURE OF NEXT OF KIN

59. SIGNATURE OF BURIAL SOCIETY

60. SIGNATURE OF CHURCH

61. SIGNATURE OF CEMETERY

62. SIGNATURE OF FUNERAL HOME

63. SIGNATURE OF MINISTER

64. SIGNATURE OF CLERGY

65. SIGNATURE OF RABBI

66. SIGNATURE OF PRIEST

67. SIGNATURE OF BISHOP

68. SIGNATURE OF ARCHBISHOP

69. SIGNATURE OF CARDINAL

70. SIGNATURE OF POPE

71. SIGNATURE OF DECEASED

72. SIGNATURE OF NEXT OF KIN

73. SIGNATURE OF BURIAL SOCIETY

74. SIGNATURE OF CHURCH

75. SIGNATURE OF CEMETERY

76. SIGNATURE OF FUNERAL HOME

77. SIGNATURE OF MINISTER

78. SIGNATURE OF CLERGY

79. SIGNATURE OF RABBI

80. SIGNATURE OF PRIEST

81. SIGNATURE OF BISHOP

82. SIGNATURE OF ARCHBISHOP

83. SIGNATURE OF CARDINAL

84. SIGNATURE OF POPE

85. SIGNATURE OF DECEASED

86. SIGNATURE OF NEXT OF KIN

87. SIGNATURE OF BURIAL SOCIETY

88. SIGNATURE OF CHURCH

89. SIGNATURE OF CEMETERY

90. SIGNATURE OF FUNERAL HOME

91. SIGNATURE OF MINISTER

92. SIGNATURE OF CLERGY

93. SIGNATURE OF RABBI

94. SIGNATURE OF PRIEST

95. SIGNATURE OF BISHOP

96. SIGNATURE OF ARCHBISHOP

97. SIGNATURE OF CARDINAL

98. SIGNATURE OF POPE

99. SIGNATURE OF DECEASED

100. SIGNATURE OF NEXT OF KIN

101. SIGNATURE OF BURIAL SOCIETY

102. SIGNATURE OF CHURCH

103. SIGNATURE OF CEMETERY

104. SIGNATURE OF FUNERAL HOME

105. SIGNATURE OF MINISTER

106. SIGNATURE OF CLERGY

107. SIGNATURE OF RABBI

108. SIGNATURE OF PRIEST

109. SIGNATURE OF BISHOP

110. SIGNATURE OF ARCHBISHOP

111. SIGNATURE OF CARDINAL

112. SIGNATURE OF POPE

113. SIGNATURE OF DECEASED

114. SIGNATURE OF NEXT OF KIN

115. SIGNATURE OF BURIAL SOCIETY

116. SIGNATURE OF CHURCH

117. SIGNATURE OF CEMETERY

118. SIGNATURE OF FUNERAL HOME

119. SIGNATURE OF MINISTER

120. SIGNATURE OF CLERGY

121. SIGNATURE OF RABBI

122. SIGNATURE OF PRIEST

123. SIGNATURE OF BISHOP

124. SIGNATURE OF ARCHBISHOP

125. SIGNATURE OF CARDINAL

126. SIGNATURE OF POPE

127. SIGNATURE OF DECEASED

128. SIGNATURE OF NEXT OF KIN

129. SIGNATURE OF BURIAL SOCIETY

130. SIGNATURE OF CHURCH

131. SIGNATURE OF CEMETERY

132. SIGNATURE OF FUNERAL HOME

133. SIGNATURE OF MINISTER

134. SIGNATURE OF CLERGY

135. SIGNATURE OF RABBI

136. SIGNATURE OF PRIEST

137. SIGNATURE OF BISHOP

138. SIGNATURE OF ARCHBISHOP

139. SIGNATURE OF CARDINAL

140. SIGNATURE OF POPE

141. SIGNATURE OF DECEASED

142. SIGNATURE OF NEXT OF KIN

143. SIGNATURE OF BURIAL SOCIETY

144. SIGNATURE OF CHURCH

145. SIGNATURE OF CEMETERY

146. SIGNATURE OF FUNERAL HOME

147. SIGNATURE OF MINISTER

148. SIGNATURE OF CLERGY

149. SIGNATURE OF RABBI

150. SIGNATURE OF PRIEST

151. SIGNATURE OF BISHOP

152. SIGNATURE OF ARCHBISHOP

153. SIGNATURE OF CARDINAL

154. SIGNATURE OF POPE

155. SIGNATURE OF DECEASED

156. SIGNATURE OF NEXT OF KIN

157. SIGNATURE OF BURIAL SOCIETY

158. SIGNATURE OF CHURCH

159. SIGNATURE OF CEMETERY

160. SIGNATURE OF FUNERAL HOME

161. SIGNATURE OF MINISTER

162. SIGNATURE OF CLERGY

163. SIGNATURE OF RABBI

164. SIGNATURE OF PRIEST

165. SIGNATURE OF BISHOP

166. SIGNATURE OF ARCHBISHOP

167. SIGNATURE OF CARDINAL

168. SIGNATURE OF POPE

169. SIGNATURE OF DECEASED

170. SIGNATURE OF NEXT OF KIN

171. SIGNATURE OF BURIAL SOCIETY

172. SIGNATURE OF CHURCH

173. SIGNATURE OF CEMETERY

174. SIGNATURE OF FUNERAL HOME

175. SIGNATURE OF MINISTER

176. SIGNATURE OF CLERGY

177. SIGNATURE OF RABBI

178. SIGNATURE OF PRIEST

179. SIGNATURE OF BISHOP

180. SIGNATURE OF ARCHBISHOP

181. SIGNATURE OF CARDINAL

182. SIGNATURE OF POPE

183. SIGNATURE OF DECEASED

184. SIGNATURE OF NEXT OF KIN

185. SIGNATURE OF BURIAL SOCIETY

186. SIGNATURE OF CHURCH

187. SIGNATURE OF CEMETERY

188. SIGNATURE OF FUNERAL HOME

189. SIGNATURE OF MINISTER

190. SIGNATURE OF CLERGY

191. SIGNATURE OF RABBI

192. SIGNATURE OF PRIEST

193. SIGNATURE OF BISHOP

194. SIGNATURE OF ARCHBISHOP

195. SIGNATURE OF CARDINAL

196. SIGNATURE OF POPE

197. SIGNATURE OF DECEASED

198. SIGNATURE OF NEXT OF KIN

199. SIGNATURE OF BURIAL SOCIETY

200. SIGNATURE OF CHURCH

201. SIGNATURE OF CEMETERY

202. SIGNATURE OF FUNERAL HOME

203. SIGNATURE OF MINISTER

204. SIGNATURE OF CLERGY

205. SIGNATURE OF RABBI

206. SIGNATURE OF PRIEST

207. SIGNATURE OF BISHOP

208. SIGNATURE OF ARCHBISHOP

209. SIGNATURE OF CARDINAL

210. SIGNATURE OF POPE

211. SIGNATURE OF DECEASED

212. SIGNATURE OF NEXT OF KIN

213. SIGNATURE OF BURIAL SOCIETY

214. SIGNATURE OF CHURCH

215. SIGNATURE OF CEMETERY

216. SIGNATURE OF FUNERAL HOME

217. SIGNATURE OF MINISTER

218. SIGNATURE OF CLERGY

219. SIGNATURE OF RABBI

220. SIGNATURE OF PRIEST

221. SIGNATURE OF BISHOP

222. SIGNATURE OF ARCHBISHOP

223. SIGNATURE OF CARDINAL

224. SIGNATURE OF POPE

225. SIGNATURE OF DECEASED

226. SIGNATURE OF NEXT OF KIN

227. SIGNATURE OF BURIAL SOCIETY

228. SIGNATURE OF CHURCH

229. SIGNATURE OF CEMETERY

230. SIGNATURE OF FUNERAL HOME

231. SIGNATURE OF MINISTER

232. SIGNATURE OF CLERGY

233. SIGNATURE OF RABBI

234. SIGNATURE OF PRIEST

235. SIGNATURE OF BISHOP

236. SIGNATURE OF ARCHBISHOP

237. SIGNATURE OF CARDINAL

238. SIGNATURE OF POPE

239. SIGNATURE OF DECEASED

240. SIGNATURE OF NEXT OF KIN

241. SIGNATURE OF BURIAL SOCIETY

242. SIGNATURE OF CHURCH

243. SIGNATURE OF CEMETERY

244. SIGNATURE OF FUNERAL HOME

245. SIGNATURE OF MINISTER

246. SIGNATURE OF CLERGY

247. SIGNATURE OF RABBI

248. SIGNATURE OF PRIEST

249. SIGNATURE OF BISHOP

250. SIGNATURE OF ARCHBISHOP

251. SIGNATURE OF CARDINAL

252. SIGNATURE OF POPE

253. SIGNATURE OF DECEASED

254. SIGNATURE OF NEXT OF KIN

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2126

CERTIFICATE OF DEATH

Reg. Dist. No.

02103

335

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL, and give nearest town) OR			
X TOWN <u>MARDELA SPRINGS</u>		<u>22 YRS</u>		TOWN <u>MARDELA SPRINGS</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>RIVERTON</u>				STREET ADDRESS (If rural give location) <u>RIVERTON</u> 1			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>LYDIA ELEANOR RADECKE</u>				DATE OF DEATH: <u>FEB 1</u> 19 <u>55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>F</u>	<u>W</u>	<u>SINGLE</u>	<u>MAY 9, 1923</u>	<u>31</u> yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>HOUSEWIFE</u>				<u>HOME</u>		<u>N.Y.</u>	
13. FATHER'S NAME:				12. CITIZEN OF WHAT COUNTRY?			
<u>JOHN RADECKE</u>				<u>U.S.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>4 NO</u>				<u>HOME</u>		<u>MRS LYDIA RADECKE</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Heart failure</u>							
ANTECEDENT CAUSE (S) DUE TO <u>Central palsy.</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C) <u>none</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
<u>0</u>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)	
				<u>Home</u>		<u>Mrs. Mardele, Wicomico Md</u>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
<u>none</u> M.							
22. I hereby certify that I attended the deceased from <u>Jan 16</u> , 19 <u>55</u> , to <u>Jan 16</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Jan 16</u> , 19 <u>55</u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Mary C Devens</u>				ADDRESS <u>MARDELA SPRINGS, MD</u>		DATE SIGNED <u>Feb 1 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>2/4/55</u>		<u>MARDELA</u>		<u>MARDELA SPRINGS, MD</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2/4/55</u>		REGISTRAR'S SIGNATURE <u>Mary C Devens</u>		24. FUNERAL DIRECTOR		ADDRESS <u>Paul J Smith, Sharptown, Md</u>	

BUREAU V. S.

FEB 8 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02104

2107

CERTIFICATE OF DEATH

Reg. Dist. No. 332

Item 7, Film G77 2-25-55 et

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Somerset</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Pr Anne</u>		19X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>82 Penninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>Beckford Ave</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH: <u>February 11 - 1955</u>			
5. SEX: <u>male</u> 6. COLOR OR RACE: <u>white</u> 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Married</u> 8. DATE OF BIRTH: <u>Aug 2 1875</u> 9. AGE last birthday <u>79</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>carner</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Ellen J. Robertson</u>				14. MOTHER'S MAIDEN NAME: <u>Ellen Parker</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>W Carlton Robertson Jr. Princess Anne Md</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Degenerative Heart Disease</u>						unknown	
ANTECEDENT CAUSE (S) DUE TO (B) <u>Generalized arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/5</u> , 19 <u>55</u> , to <u>2/11</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>2-11</u> , 19 <u>55</u> , and that death occurred at <u>4:50</u> P, from the causes and on the date stated above.							
SIGNATURE <u>William R. Ellis, Jr.</u>		M. D. <u>Salisbury, Md.</u>		DATE SIGNED <u>2-12-55</u>			
23. BURIAL, CREMATION, REMOVAL, (SPECIFY) <u>burial</u>		DATE THEREOF <u>Feb 14, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		LOCATION (City, town, or county) (State) <u>Salisbury Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2-16-55</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		24. FUNERAL DIRECTOR <u>James L. Newman</u>		ADDRESS <u>Princess Anne</u>	

RECEIVED

FEB 16 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02105

2108

CERTIFICATE OF DEATH

Reg. Dist. No. 332....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Worcester</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Pocomoke</u>		28-42-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>Box 141</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
OF DECEASED: (Type or Print) <u>Frank A Scott</u>				OF DEATH: <u>February 4</u> 19 <u>55</u>			
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>March 31, 1876</u>	9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Stationary Engineer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Maintenance</u>		11. BIRTHPLACE (State or foreign country): <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY: <u>USA</u>	
13. FATHER'S NAME: <u>Robert Henry Scott</u>				14. MOTHER'S MAIDEN NAME: <u>Dorothy Harper</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>4 yrs</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Robert H. Scott, Pocomoke, Md</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Carcinoma of liver</u>						6 months	
ANTECEDENT CAUSE (B) <u>Generalized arteriosclerosis</u>						10 yrs	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>(260X)</u>						5 yrs	
C) <u>Sealioles mellitus</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>1-15-55</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Carcinoma of liver</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-10</u> , 19 <u>55</u> , to <u>2-4</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>2-4</u> , 19 <u>55</u> , and that death occurred at <u>11:40 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>SA Brille</u>		M. D. <u>2267 N. Division St</u>		DATE SIGNED <u>2-4-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>2/6/55</u>		DATE THEREOF		NAME OF CEMETERY OR CREMATORY <u>Salim M.E. Cemetery Pocomoke Md.</u>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR <u>2-5-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloray</u>		24. FUNERAL DIRECTOR <u>Henry B. Watson Pocomoke</u>		ADDRESS	

RECEIVED
FEB 9 1955
BUREAU V. S.

1

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2109

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>SALISBURY</u>				TOWN <u>SALISBURY</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>PENINSULA GENERAL HOSPITAL</u>				<u>414 ELIZABETH STREET</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
<u>SERRES</u>				<u>2 23 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>		<u>FEBRUARY 23 1955</u>	<u>23</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>none</u>		<u>none</u>		<u>MARYLAND</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>HARRY THOMAS SERRES</u>				<u>MYRNA MASSEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>9</u>						<u>MYRNA MASSEY SERRES</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
761.5 IMMEDIATE CAUSE (A)				<u>Premature Labor</u>			
ANTECEDENT CAUSE(S) DUE TO (B)				<u>Premature Rupt Membrane</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
				<u>24 hrs</u>			
				<u>78 hrs</u>			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
<u>NONE</u>				<u>NONE</u>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				<u>NONE</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> et work Not while <input type="checkbox"/> et work		21f. HOW DID INJURY OCCUR?			
		<u>M.</u>					
22. I hereby certify that I attended the deceased from <u>2/23/55</u> to <u>2/23/55</u> , that I last saw the deceased alive on <u>2/23/55</u> , and that death occurred at <u>7:40 A.M.</u> from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Glorie Christensen</u>				<u>Salisbury, Md</u>		<u>2/26/55</u>	
M.D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>cremation</u>		<u>2/24/55</u>		<u>Peninsula General Hospital</u>		<u>Salisbury, Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>2-26-55</u>		<u>Mary W. Holloway</u>		<u>Peninsula General Hospital</u>			
DATE							

982599V99V

CERTIFICATE OF DEATH

Reg. Dist. No.

1. SEX AND AGE AT DEATH

2. PLACE OF DEATH

3. CAUSE OF DEATH

4. MANNER OF DEATH

5. DATE OF DEATH

6. TIME OF DEATH

7. SIGNATURE OF DECEASED

8. SIGNATURE OF WITNESSES

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF CORONER

11. SIGNATURE OF JURY

12. SIGNATURE OF JUDGE

13. SIGNATURE OF CLERK

14. SIGNATURE OF SHERIFF

15. SIGNATURE OF SHERIFF'S DEPUTY

16. SIGNATURE OF SHERIFF'S CLERK

17. SIGNATURE OF SHERIFF'S DEPUTY CLERK

18. SIGNATURE OF SHERIFF'S DEPUTY CLERK

19. SIGNATURE OF SHERIFF'S DEPUTY CLERK

20. SIGNATURE OF SHERIFF'S DEPUTY CLERK

21. SIGNATURE OF SHERIFF'S DEPUTY CLERK

22. SIGNATURE OF SHERIFF'S DEPUTY CLERK

23. SIGNATURE OF SHERIFF'S DEPUTY CLERK

24. SIGNATURE OF SHERIFF'S DEPUTY CLERK

BUREAU V. S.

FEB 28 1955

RECEIVED

DATE RECEIVED

INDICATOR

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT OF BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT OF THE COUNTY OF BALTIMORE, MARYLAND. IT IS TO BE KEPT FOR A PERIOD OF FIFTY YEARS.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55-1064

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02107

2127

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Wicomico</i>		MARYLAND		STATE <i>Maryland</i> COUNTY <i>Wicomico</i>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <i>White Haven</i>		<i>3 days</i>		TOWN <i>White Haven</i>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>00</i>				STREET ADDRESS (If rural give location) <i>1</i>			
3. NAME OF DECEASED (First) (Middle) (Last) <i>Edward G. Shores</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>Feb. 6 1955</i>			
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>widowed</i>	8. DATE OF BIRTH <i>Nov. 24, 1868</i>		9. AGE last birthday <i>86</i> yrs.	IF UNDER 1 YEAR Months <i>2</i> Days <i>13</i>	IF UNDER 24 HRS. Hours <i></i> Min. <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Ship yard</i>		11. BIRTHPLACE (State or foreign country) <i>Dames Quarter, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Robert Shores</i>				14. MOTHER'S MAIDEN NAME <i>unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>no</i>		16. SOCIAL SECURITY NO. <i>212-14-1748</i>		17. INFORMANT & ADDRESS <i>Edna Shores - White Haven, Md.</i>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>1420.0 IMMEDIATE CAUSE</i> (A) <i>Acute Cardiac Failure</i>						<i>1 hour</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Arteriosclerotic Heart Disease</i>						<i>10 years</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Acute Pulmonary Edema</i>						<i>1 hour</i>	
19a. DATE OF OPERATION <i>0</i>		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>5 Jan., 1948</i> , to <i>6 Feb., 1955</i> , that I last saw the deceased alive on <i>6 Feb., 1955</i> , and that death occurred at <i>11:57 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>Delia H. Saunders</i>				ADDRESS (Street, city, town, state) <i>M. D. Nantuxbe Md.</i>		DATE SIGNED <i>2/7/55</i> (State)	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>2/9/55</i>		NAME OF CEMETERY OR CREMATORY <i>Bivalve Cemetery</i>		LOCATION (City, town, or county) <i>Bivalve, Maryland</i>	
24. REC'D BY REGISTRAR <i>Feb. 9-1955</i>		REGISTRAR'S SIGNATURE <i>Mary W. Hollway</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Cornelius H. Messick</i>		ADDRESS <i>Bivalve, Md.</i>	

CERTIFICATE OF DEATH

5137

DATE OF DEATH

PLACE OF DEATH

DECEASED
Name of deceased

DECEASED
Name of deceased

DATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DECEASED
Name of deceased

DECEASED
Name of deceased

BUREAU V. 1

FEB 10 1955

RECEIVED

DATE OF DEATH

NAME OF DECEASED

2128

CERTIFICATE OF DEATH

Reg. Dist. No. 02108
53

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town) <u>X</u> TOWN <u>Hebron</u>		LENGTH OF STAY (in this place) <u>48 Yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hebron</u> <u>X</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00 Smith at Church St.</u>				STREET ADDRESS (If rural give location) <u>Smith at Church</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>ANNIE</u> <u>WHEATLEY</u> <u>SMITH</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>2</u> <u>2</u> <u>1955</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>Dec. 11, 1866</u>	9. AGE last birthday <u>88</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>House Wife</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME: <u>Henry Wheatley</u>				14. MOTHER'S MAIDEN NAME: <u>Mahal Hayland</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>Roland Smith, Hebron, Maryland</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.2 IMMEDIATE CAUSE (A) <u>Chronic Myocarditis</u>							
ANTECEDENT CAUSE (S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 1st</u> , 19 <u>55</u> , to <u>Feb. 2nd</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Feb. 2nd</u> , 19 <u>55</u> , and that death occurred at <u>6:30 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>William Emrich</u>				DATE SIGNED <u>Feb. 3-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/5/55</u>		NAME OF CEMETERY OR CREMATORY <u>Hebron Cemetery</u>		LOCATION (City, town, or county) (State) <u>Hebron, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2-5-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. McIlroy</u>		24. FUNERAL DIRECTOR ADDRESS <u>The Hill & Johnson Co. Salisbury, Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

EX-117-V

100

BUREAU V. S.

FEB 9 1955

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 332

2110

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Queen Anne</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>12 SALISBURY</u>		LENGTH OF STAY (in this place) <u>11 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>CENTREVILLE 17X-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>91 Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>CHARLES PLUMMER SMITH</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>FEBR. 20 19 55</u>			
5. SEX: <u>M.</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH: <u>5-10-1880</u>	9. AGE last birthday <u>74</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Smith.</u>				14. MOTHER'S MAIDEN NAME: <u>PLUMMER.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Hospital records</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>332X Recurrent cerebral thrombosis</u>						<u>15 min.</u>	
ANTECEDENT CAUSE (S) (B) <u>Arteriosclerosis</u>						<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Arteriosclerotic cardiovascular disease</u>						<u>?</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>M.</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/10</u> , 19 <u>55</u> , to <u>2/20</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>2-20</u> , 19 <u>55</u> , and that death occurred at <u>10:30</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>Dr. J. Guerman</u>				ADDRESS <u>Deer's Head State Hospital, Salisbury</u> DATE SIGNED <u>2/20/55</u>			
23. BURIAL CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>2/22/55</u>		NAME OF CEMETERY OR CREMATORY <u>Church Hill</u>		LOCATION (City, town, or county) (State) <u>Church Hill Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2-21-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>		24. FUNERAL DIRECTOR <u>Edgar J. Lane</u>		ADDRESS <u>Church Hill</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 23 1955

BUREAU V. S.

2129

02110

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Somerset</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR	
TOWN <u>Parsonsborg</u>		<u>1 week</u>		TOWN <u>Crisfield</u>		<u>19-39-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>RFD # 1</u>				STREET ADDRESS (If rural, give location) <u>Maryland, Md.</u>			
3. NAME OF DECEASED:				4. DATE OF DEATH			
(First)		(Middle)		(Last)		(Month) (Day) (Year)	
<u>Henry George</u>		<u>Swift</u>				<u>2 22 19 55</u>	
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<u>M</u>		<u></u>		<u>Married</u>		<u>Aug. 6, 1871</u>	
						9. AGE last birthday: <u>83</u> yrs.	
						IF UNDER 1 YEAR: Months Days	
						IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Retired farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>Self-employed</u>		11. BIRTHPLACE (State or foreign country): <u>Rehobeth, Md.</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Theodore Swift</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
<u>No</u>				<u>None</u>		<u>Hartlon Swift, RFD # 1 Parsonsborg, Md.</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Pulmonary Tuberculosis</u>						<u>3 yrs</u>	
Antecedent cause(s) (b) <u>Arterio Sclerosis</u>							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Emil C. Boyer</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>2-22-55</u>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>BURIAL</u>		DATE THEREOF: <u>FEB. 25, 1955</u>		NAME OF CEMETERY OR CREMATORY: <u>SUNNYSRIDGE CEMETERY</u>		LOCATION (City, town, or county) (State): <u>CRISFIELD, MARYLAND</u>	
DATE REC'D BY LOCAL REG: <u>2-22-55</u>		REGISTRAR'S SIGNATURE: <u>Mary W. Holloway</u>		24. FUNERAL DIRECTOR: <u>BRADSHAW & SONS - 531 MAIN ST. - CRISFIELD, MD.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 25 1955

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2111

CERTIFICATE OF DEATH

02111

332

Dr. Carrie Hearne

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
12 TOWN Salisbury				TOWN Salisbury		12	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
82 Pen. Gen. Hospital				114 Fooks St.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) WILLIAM		(Middle) JAMES		(Last) TAYLOR		(Month) (Day) (Year)	
						FEB. 17 th 19 55	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	White	Widowed	June 9th, 1881	73 yrs.	Months 8	Days 8	Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life or retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Retired Fireman at Wicomico Hotel					Greensboro, Delaware		USA
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
William James Taylor				XXXXXXXXXXXXXXXXXXXX Elizabeth Parsons			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				Mr. Harvey R. Taylor (Son) 114 Fooks St			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
331X IMMEDIATE CAUSE (A) Cerebral Hemorrhage				Salisbury, Maryland			
ANTECEDENT CAUSE(S) DUE TO (B) Arteriosclerosis							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 18, 1955 , to Feb 17, 1955 , that I last saw the deceased alive on Feb 17, 1955 , and that death occurred at 3:00 P.M. from the causes and on the date stated above.							
SIGNATURE Carrie Hearne				ADDRESS (Street, city, town, state)		DATE SIGNED	
				M.D. West Church St. Salisbury, Maryland		Feb 18 1955	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Feb. 20, 1955		Parsons Cemetery		Salisbury, Maryland	
24. RECEIVED BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE Feb. 21, 1955		Mary Holloway		HOLLOWAY & COMPANY		SALISBURY MARYLAND	

INSTRUCTIONS

1. This form is to be filled out by the physician or other qualified person who has attended the deceased and is to be submitted to the Bureau of Health Statistics, Maryland State Department of Health, Baltimore, Md.

2. The information furnished on this form is for the purpose of compiling statistics and is not to be used for any other purpose.

3. The information furnished on this form is to be confidential and is not to be disclosed to any person other than those authorized to receive it.

4. The information furnished on this form is to be used for the purpose of compiling statistics and is not to be used for any other purpose.

5. The information furnished on this form is to be confidential and is not to be disclosed to any person other than those authorized to receive it.

6. The information furnished on this form is to be used for the purpose of compiling statistics and is not to be used for any other purpose.

7. The information furnished on this form is to be confidential and is not to be disclosed to any person other than those authorized to receive it.

8. The information furnished on this form is to be used for the purpose of compiling statistics and is not to be used for any other purpose.

9. The information furnished on this form is to be confidential and is not to be disclosed to any person other than those authorized to receive it.

10. The information furnished on this form is to be used for the purpose of compiling statistics and is not to be used for any other purpose.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE

<p>1. Name of deceased</p>		<p>2. Sex</p>		<p>3. Age</p>		<p>4. Date of birth</p>		<p>5. Date of death</p>		<p>6. Place of death</p>		<p>7. Cause of death</p>		<p>8. Manner of death</p>		<p>9. Signature of physician</p>		<p>10. Signature of registrar</p>	
<p>11. Name of informant</p>		<p>12. Address of informant</p>		<p>13. Occupation of informant</p>		<p>14. Date of information</p>		<p>15. Date of registration</p>		<p>16. Date of filing</p>		<p>17. Date of completion</p>		<p>18. Date of submission</p>		<p>19. Date of receipt</p>		<p>20. Date of filing</p>	

BUREAU V. S.

FEB 23 1958

RECEIVED
BUREAU V. S.

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02112

2112

Item 9, Film 177 2-14-55 et

CERTIFICATE OF DEATH

Reg. Dist. No. 932

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Wicomico</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>Queen Anne's</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salisbury</u>	LENGTH OF STAY (in this place) <u>7 mos</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Camichael</u>	<u>17X-2</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deens Head Hospital</u>		STREET ADDRESS (If rural give location) <u>None</u>	<u>✓</u>
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>Carrie</u>	(Middle)	(Last) <u>Wanner</u>	DATE OF DEATH: <u>Feb. 8</u> 19 <u>55</u>
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>August 16, 1906</u>
		9. AGE last birthday <u>48</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housework</u>	10B. KIND OF BUSINESS OR INDUSTRY: <u>None</u>	11. BIRTHPLACE (State or foreign country): <u>Delaware</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME: <u>Will Bell</u>		14. MOTHER'S MAIDEN NAME: <u>Fannie Gould</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>if no</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS: <u>Hospital records</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
(A) IMMEDIATE CAUSE <u>170X Generalized Ca.</u>			<u>1 year</u>
(B) ANTECEDENT CAUSE (S) <u>Adenocarcinoma of left breast</u>			<u>5 years</u>
(C) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>6/22, 1954</u> to <u>2/8, 1955</u> that I last saw the deceased alive on <u>2/7</u> , 19 <u>55</u> , and that death occurred at <u>2:30</u> AM, from the causes and on the date stated above.			
SIGNATURE <u>Dr. J. J. J. J.</u>		DATE SIGNED <u>2.8.55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/11/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Denton</u>		LOCATION (City, town, or county) (State) <u>Denton Md.</u>	
24. FUNERAL DIRECTOR		ADDRESS	
REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		<u>J. E. Boulais Greensboro, Md.</u>	

RECEIVED
FEB 10 1955
BUREAU V. S.

1

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02113

2113

CERTIFICATE OF DEATH

Reg. Dist. No. 332

DR. BURTON

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		STATE Maryland COUNTY Wicomico		CITY Powellville		TOWN Powellville	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
TOWN Salisbury				STREET ADDRESS (If rural give location)		ADDRESS R.D. # 2 Pittsville, Md.	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) LESTER (Middle) WILLIAM (Last) WHITE				(Month) Feb. (Day) 17 (Year) 1955			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Feb. 19, 1900	9. AGE last birthday 54 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY on own farm		11. BIRTHPLACE (State or foreign country) R.D. # 2 Pittsville, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Clayton White				14. MOTHER'S MAIDEN NAME Sarah Elizabeth Adkins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. Laura A. White (Wife) R.D. # 2			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				Pittsville, Maryland (Powellville)			
IMMEDIATE CAUSE (A) Coronary Thrombosis				1 day			
ANTECEDENT CAUSE(S) DUE TO (B) Arteriosclerotic heart disease				Years			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) congestive cardiac failure				Years			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Hypertension				Years			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/> M. <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 9/16/1955 , to 2/17/1955 , that I last saw the deceased alive on 2/17/1955 , and that death occurred at 9:00 AM , from the causes and on the date stated above.							
SIGNATURE [Signature]		M.D. Professor J. B. Bldg.		ADDRESS (Street, city, town, state)		DATE SIGNED Feb. 18 1955	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Feb. 19, 1955		NAME OF CEMETERY OR CREMATORY Adkins Cemetery (Powellville)		LOCATION (City, town, or county) R.D. # 2 Pittsville, Md.	
24. REC'D BY REGISTRAR Mary Holloway		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
DATE Feb. 21, 1955							

MARIANA STATE DEPARTMENT OF HEALTH-BALTIMORE 18

FEB CERTIFICATE OF DEATH

1. NAME OF DECEASED (Print name and last name)		2. DATE OF DEATH (Month, day, year)	
3. PLACE OF DEATH (City, State, and Country)		4. TIME OF DEATH (Hour, minute)	
5. SEX (Male or Female)		6. AGE (In years, months, and days)	
7. OCCUPATION (If any)		8. CAUSE OF DEATH (Immediate cause)	
9. DISEASE OR INJURY (Underlying cause)		10. MANNER OF DEATH (Natural, Accidental, Suicide, Homicide, or Undetermined)	
11. SIGNATURE OF PHYSICIAN (If known)		12. SIGNATURE OF DEATH REGISTRAR (If known)	
13. SIGNATURE OF WITNESS (If known)		14. SIGNATURE OF DECEASED (If known)	

This certificate is to be filled out by the physician or other qualified person who has attended the deceased or by the death registrar or other qualified person who has attended the deceased. It is to be filled out as soon as possible after death and before the body is buried or cremated. It is to be filled out in duplicate and one copy is to be retained by the death registrar and the other copy is to be sent to the State Department of Health.

RECEIVED
 FEB 21 1955
 BUREAU V. R.

2114

CERTIFICATE OF DEATH

Reg. Dist. No.

333

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>		<u>3 yrs.</u>		TOWN <u>Baltimore City</u>		<u>3801.4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location) <u>2041 Fulton Avenue</u>			
3. NAME OF DECEASED: (Type or Print)		(First) <u>CORA</u>		(Middle) <u>VIOLET</u>		(Last) <u>WRIGHT</u>	
4. DATE (Month) OF DEATH: <u>2</u>		(Day) <u>3</u>		(Year) <u>1955</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH: <u>4/29/1918</u>	9. AGE last birthday <u>36</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>None</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>- -</u>	11. BIRTHPLACE (State or foreign country): <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Charles Wright</u>				14. MOTHER'S MAIDEN NAME: <u>Bertha Carter</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>unk.</u>		(If Yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT & ADDRESS: <u>Hospital Records</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Myasthenia gravis</u>						<u>14 years</u>	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/25</u> , 1951, to <u>2/3/55</u> , 19..., that I last saw the deceased alive on <u>2/3/55</u> , 19..., and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Dr. V. J. Guerman</u>				ADDRESS <u>M. D. Deer's Head State Hospital, Salisbury</u>		DATE SIGNED <u>2.3.55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb 8th/55</u>		NAME OF CEMETERY OR CREMATORY <u>mt Calvary</u>		LOCATION (City, town, or county) (State) <u>A.A. Co.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2-8-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Oliver O Wilson</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

